The preliminary report of the Mayor's Action Task Force on Discharged Psychiatric Patients

Chairperson: Dr. Reva Gerstein, O.C., Psych.C.

METROPOLITAN
TORONTO
CENTRAL
LIBRARY
Municipal Reference

Even in the darkest of times, we have the right to expect some illumination. It may well come less from theories and concepts than from the uncertain flickering and often weak light that some men and women, in their lives and works, will kindle and shed over the time span given to them on earth.

Hannah Arendt
Men in Dark Times

This report is dedicated to the many fine people in this City who have laboured with dedication and vision, often with inadequate resources, to create a society where the psychiatrically disabled can realize their potential.

CONTENTS

Acknowledgements: .....Page ii

Foreward: 1

Mandate from Toronto City Council: 2

1. Introduction 4

2. Summary of Recommendations 8

3. The Historical Context: Perspectives on Mental Health and Illness 13

4. Overview of the Toronto Situation 19

5. Housing 33

6. Crisis Intervention Services 62

7. Coordination of Aftercare Services 75

8. Attitudes: Barriers to Community Mental Health 78

Appendices

A. A comparison of physical and personal care standards 80
in regulating boarding homes.

B. Greater Vancouver Mental Health Service: Venture. In-Patient and
After-Hours Psychiatric Emergency Service (A.H.P.E.S)
Expenditures 1982/1983 105

C. Proposed Crisis Centre (15 Residents) Funding Estimates 106

ACKNOWLEDGEMENTS

Although I was appointed as a "one person Task Force", much of what has been accomplished over the past nine months is due to the combined thought and effort of many concerned individuals. This Task Force benefitted greatly from the considerable resources made available through the Toronto Department of Public Health. In particular, the decision to second the Health Advocate, Marilou McPhedran, to act as the Task Force Coordinator, has proven to be both efficient and effective.

I welcomed the suggestion for an Advisory Committee and am indebted to Ms. McPhedran, David Goyette, Alderman David Reville and Executive Alderman Anne Johnston for their assistance in assembling a committee which has provided me with invaluable information and support.

I wish to extend my sincere thanks to each of the members of the Advisory Committee:

Pat Capponi	Editor, Cuckoo's Nest
Al Erlenbusch	Ministry of Health
Karen Goldenberg	Community Occupational Therapy Associates
David Goyette	Office of the Mayor
John Kamin	Parkdale Activity & Recreation Centre - Board
Alexander S. Macpherson	Medical Officer of Health, City of Toronto
Mary Marshall	Canadian Mental Health Association
Ken Munro	On Our Own

Mary Ellen Polak — Supportive Housing Coalition of Metro Toronto

Joel Shapiro — Ministry of Community and Social Services

This report has grown from a twenty page summary to almost one hundred pages. I have never believed that "big is better" when it comes to reports but as my work progressed, it became clear that a much more comprehensive document was warranted.

I wish to thank those who have been of principal assistance to Marilou and me in the face of a very demanding production schedule:

Liss Jeffrey, who has written extensively in this field, is currently an instructor in Communications and a graduate student in the Environmental Studies Department at York University;

Cindy McDougall, who has provided us with needed legal research, is a third year law student at the University of Toronto;

Linda Rosenbaum, Health Promotion Officer with Toronto's Department of Publice Health, who has provided invaluable editorial assistance on very short notice;

Pauline Fox, the present Task Force Secretary and Elizabeth Walker, the former Task Force Secretary, both of whom have worked long hours before the video display terminal to help produce what I hope will prove to be a useful document, for years to come.

Many many people gave generously of their time and skills. The preparation of this report was greatly aided by D'Arcy Farlow, Susan Atkinson, Ian King, Bob Stone, Anne Moon, Marcia Moss, Hazel Farley and Marlyn Taylor.

FOREWARD:

On February 9, 1983 Mayor Arthur Eggleton appointed Dr. Reva Gerstein to chair an inquiry into the situation surrounding discharged psychiatric patients living in the City of Toronto. The Mayor asked Dr. Gerstein to prepare a final report from this Task Force which developed a "co-ordinated problem-solving approach" to the concerns raised during the course of her inquiry. As well, Mayor Eggleton stipulated that the title of the Task Force include the word "Action". It was anticipated that Dr. Gerstein and her advisors would actively respond to events and problems throughout the course of the inquiry, as they arose, rather than restricting themselves to making recommendations in a final report. "Action" was also used to indicate that the Mayor and City Council had made a commitment toward immediate implementation of recommendations wherever possible.

Therefore, this report is not a complete catalogue of the work undertaken by the Task Force in the past eight months. Rather, the most significant problems facing discharged psychiatric patients are identified and discussed. Proposals are included which address four of those problem areas: 1) housing, 2) crisis intervention, 3) coordination of aftercare services, and 4) public education. All of these proposals are predicated on coordination and cooperation among all three levels of government: the City of Toronto, Metropolitan Toronto, and the Province of Ontario.

At its meeting of May 16, 1983, the Council of the City of Toronto decided that the Task Force's mandate would include the appointment of an Advisory Committee (the members of this committee are listed on page ii of this report). As well, it was decided that public meetings would be held on a regular basis and that the final version of the draft report would be discussed at an evening public meeting in the Council Chambers held prior to the presentation of the Final Report to members of Council. Copies of the Preliminary Report of the Task Force will be available as of Thursday November 24th, and the public meeting has been scheduled for 7:00 p.m. in the Council Chambers on Wednesday November 30. Invitations to individuals and organizations have been issued and public notices will be placed in Toronto's three daily newspapers. Deputations will be welcome. All inquiries and comments regarding the Preliminary Report should be addressed to:

Ms. Marilou McPhedran, Coordinator
Mayor's Action Task Force on Discharged Psychiatric Patients
Department of Public Health, 7th Floor, East Tower, City Hall
Toronto, Ontario M5H 2N2 Telephone: 947-7450

MANDATE FROM TORONTO CITY COUNCIL

In his inaugural speech to City Council on December 3, 1982, Mayor Arthur Eggleton outlined a proposal for the Action Task Force to examine and advocate the needs of discharged psychiatric patients in Toronto. Mayor Eggleton acknowledged the many previous attempts to improve the quality of life for these citizens, but he noted that "It is clear that we continue to face the unacceptable reality that many ex-patients are not provided with a satisfactory level of accommodation and aftercare."

Mayor Eggleton made reference to the several initiatives taken by concerned officials at the municipal and provincial levels of government and indicated his concern "about the need for a focus for the City's work, and the ability of Council to have a consensus of views placed before it at one point in time."

In outlining the purpose of the Task Force, the Mayor noted the existence of sufficient documentation regarding discharged psychiatric patients and recommended that the Task Force "review the variety of housing, social, medical, legal, crisis care, income and discharge issues affecting the well-being of discharged patients across the City and recommend a precise course of action to Council."

Further to Executive Reports Number 11 (February 9, 1983) and Number 22 (May 16, 1983), City Council adopted the terms of reference for the Task Force as follows:

> To investigate current studies and pertinent data, consult with all affected and interested parties, and report to City Council through the Executive Committee on means of achieving a continuity to programs and care for discharged patients in Toronto.
>
> In particular, to report to Council on the means of achieving resolution of the following matters in relation to the present and future well-being of discharged patients:
>
> the current provision and anticipated need for an adequate supply and quality of residential settings for ex-patients, from high support to minimal supervision types;
>
> the necessary degree of regulation of privately operated accommodation for ex-patients;

the current and desired standard of public health, medical, social and recreational aftercare for ex-patients;

the discharge policy of the Queen Street Mental Health Centre;

Federal and Provincial government policy regarding the distribution through funding of group homes and other forms of housing for ex-patients across Metropolitan Toronto;

the provision of adequate income support;

the issue of legal and tenant rights; and

the need for public education and sensitization to the ex-patient community.

1. INTRODUCTION

I accepted the Mayor's request to chair this Task Force because of his firm conviction that the City must play a meaningful role in dealing with the problems faced by discharged psychiatric patients. It also became clear to me that the majority of the members on City Council were also commited to finding a solution to these problems.

This has been the most challenging assignment of my life. My past experience in chairing or participating on government commissions or federal and provincial task forces, in no way paralleled the complexity of the problems faced by this Task Force.

My experience in this field goes back 30 years, to my work with Dr. Clarence Hincks and Dr. J. D. Griffin, pioneers in the mental heath movement. As well, I worked on the famous Tydhurst report of 1952, which laid the groundwork for the process of deinstitutionalization. Neither my former colleagues or I ever fully appreciated the need for a comprehensive range of aftercare support services, including adequate housing. Without such a continuum of service, however, it has become impossible for many discharged psychiatric patients, particularly the chronically disadvantaged, to live with dignity in our communities. As we know, these communities have not always been friendly or accepting -- and some have even been hostile.

My task has often seemed overwhelming and demanding. I have given it all my energy, strength and whatever intellectual and imaginative gifts I may possess. My burden has been immeasurably lightened by the calibre of competence and sensitivity of my Task Force Coordinator, Marilou McPhedran, who has worked so closely with me. The cooperation of the "City Hall Folk", politicians and other officials, has been great -- responding to all my requests. Professionals and other staff from agencies and organizations in the field, all have shared their studies, hopes, dreams and plans with me. Civil servants of all ranks from every Ministry have been helpful as well. Whatever has been accomplished has been through a team approach; concepts were moulded, hammered and fine-tuned by an army of helpers, especially my Advisory Committee who were ever on call.

A great change in the last three decades has been the shift from "charitable" thinking to an appreciation of the social rights of human beings. However, we still seem to drag dinosaurs of the past on wheels into our present thinking.

We have too much evidence that the back wards of the former institutions have shifted to the community. In these former institutions, patients were too often out of sight and without a voice. Now, in the community they may still be invisible to many, but there are those among them who speak with great courage, though still some trepidation. The Pat Capponis of this city and a handful of other discharged psychiatric patients have worked diligently and zealously to make their plight known to the public.

The mandate as received by me, was extraordinarily broad - the Task Force could have carried on for several years, written an encyclopedia and made a thousand recommendations. I have chosen to narrow my mandate, to focus our work on the chronically disadvantaged - that core of discharged psychiatric patients who suffer most and are in greatest need.

These are the people who live with fear and great courage - who spoke out with anxious voices at our public hearings to tell us of suicides; of the fear of being transferred in the night to a strange boarding home; of finding their meagre belongings on the sidewalk; of what it is to lack a decent income or live barely beyond the level of survival. They told us of being barred from hostels or living in fear in others; of being taken by police from one hospital to another during a crisis, without help forthcoming. They told us of where they live, of some fellow boarders who move like zombies; eating silently together and then returning to their boredom.

It's a long story, often unpleasant. It's a story of vulnerable, sensitive human beings without a feeling of value - so near the rock bottom of despair. It is these people, in this city, that this report addresses.

The number of chronically disadvantaged discharged psychiatric patients in Toronto is difficult to come by. Hard data are not available - the best calculated guess of the numbers in Toronto of this core group is around 1,800. The report strives not to pigeon-hole 1,800 human beings, but rather to develop a plan for finding solutions for these people based on an appreciation for their individual dignity. It has been my goal to find out how there can be better working mechanisms among the various levels of government so that human needs become the real determinant of policies. We must strive to develop means of meeting these needs rather than making people fit the needs of our bureaucracies, agencies and institutions.

The format of this report may seem cool, objective or academic to those people who are more comfortable with passionate expressions. Let me make it very clear to all who read this report that behind the words and statistics is a real, tough human problem which dictates a sense of urgency to the deliberations which must follow from here. The problem will not go away - if this situation is

allowed to deteriorate, the blemish becomes more difficult to eradicate.

The key proposals in this report are:

1) Housing with the full range of appropriate services is given the highest priority;

2) Hostels, police and cooperative housing groups have identified the need for support services not currently delivered by general hospitals. This led to my proposal for a range of crisis intervention services, including a short term free-standing centre complementary to the extension of services delivered by general hospitals, emergency wards and community-based agencies.

3) One cannot help but be impressed and confused by the Metro District Health Council 1983 Inventory of Adult Mental Health Services which catalogues over 300 pages of titles of services. Who are they? Whom do they help? And why do we still have so many gaps in service when there are so many service agencies? These are questions that immediately come to mind. The Parkdale Working Group (under the auspices of the Ministry of Health), has identified after more than a year in operation, that coordination of services is a key problem. My experience would lead me to concur with this assessment. Good coordination will have to be City-wide and Metro-wide, with considerable provincial support. It should become the means whereby we avoid long term funnelling and "ghettoizing" of any one area of this City. Such a coordinated plan can only come about by concerted and articulated political will from the City of Toronto, Metro Toronto, and the Province of Ontario. No one level of government can deal with this problem in isolation. I am convinced that the Provincial Cabinet as a whole must place a high priority on this particular group by designating a lead ministry and ensuring cooperation among the Ministries of Health, Municipal Affairs & Housing, Community & Social Services, and the Secretariat for Social Development. So too, the Toronto City Council should designate a lead Department and ensure cooperation among the Departments of Public Health, Planning & Development, Buildings & Inspections, Parks & Recreation, Legal and Fire. It will take supreme effort to smooth the vertical and horizontal mechanisms for action within and among levels of government, ministries and departments. The time for political scapegoating has passed. What we need now is the exercise of political will and action.

The public also has a responsibility. Politicians respond to the public will, and it is the public who will have to learn what being your brother's keeper in the 1980s really means. Caring is a noble art. It not only enriches the one who cares and gives

with heart, mind and hand, but it also recognizes that the recipient must be the basic part of the equation: What does he or she want? Need? Feel? Care about? A sense of dignity is just as important to the one who receives as it is to the one who gives. The prevalent attitude of "not on my street" toward the emotionally disadvantaged has to be looked at and challenged. Without a change in public attitude, no humane, dignified solution is possible. There is a great need for dedicated groups - religious, volunteer, self-help. All will require public support to accomplish these ends. I am heartened by the efforts of many of these groups toward promoting community acceptance of supportive housing.

We who consider ourselves as civilized should pause and think for a moment. A great City such as ours is not to be judged only by its beautiful buildings, its clean streets, its subway system or its harbourfront. The true measure of a civilization rests upon how it cares for its vulnerable members.

Dr. Reva Gerstein, O.C., Psych.C.
November, 1983

2. SUMMARY OF RECOMMENDATIONS

RECOMMENDATION #1: THAT THE CITY OF TORONTO RE-AFFIRM ITS SUPPORT IN PRINCIPLE FOR GROUP HOMES AS A NECESSARY COMPONENT IN THE RANGE OF SUPPORTIVE HOUSING FOR DISCHARGED PSYCHIATRIC PATIENTS.

RECOMMENDATION #2: THAT METROPOLITAN TORONTO AND THE CITY OF TORONTO DEMONSTRATE THEIR COMMITMENT TO THE SOCIAL BENEFITS OF GROUP HOMES BY MAKING AVAILABLE AT A NOMINAL COST ONE HOUSE EACH TO BE USED AS A GROUP HOME, OPERATED ON A NON-PROFIT BASIS; THE LOCATION AND OPERATION OF EACH SUCH HOUSE TO BE DETERMINED IN CONSULTATION WITH THE SUPPORTIVE HOUSING COALITION, TO BE PROVIDED FOR DISCHARGED PSYCHIATRIC PATIENTS AND TO BE IN OPERATION BY THE SUMMER OF 1984.

RECOMMENDATION #3: THAT THE PROVINCE OF ONTARIO IN COOPERATION WITH THE CITY OF TORONTO DEVELOP AND PUT IN PLACE THE CONTRACT AFTERCARE PROJECT, (C.A.P.) TO COMPRISE THE FOLLOWING COMPONENTS:

1) AN AGREEMENT BETWEEN THE PROVINCE OF ONTARIO AND THE CITY OF TORONTO BY WHICH THE PROVINCE PROVIDES FINANCIAL RESOURCES FOR THE REPAIR AND REHABILITATION OVER THE NEXT 5 YEARS OF 10 EXISTING BOARDING HOUSES IN THE CITY OF TORONTO, BEGINNING IN THE PARKDALE NEIGHBOURHOOD, IN EXCHANGE FOR THE CITY'S UNDERTAKING TO IMPLEMENT, ADMINISTER AND MONITOR THE C.A.P.

2) THE CITY WILL PROVIDE FINANCIAL RESOURCES TO THE OWNER/OPERATOR OF AN EXISTING BOARDING HOUSE FOR REHABILITATION AND REPAIR OF THE PROPERTY IN EXCHANGE FOR:

   i) COMPLIANCE WITH PHYSICAL STANDARDS SPECIFIED IN A CONTRACT (FOR FURTHER DETAILS, SEE SCHEDULE A OF THE DRAFT PROTOTYPE CONTRACT IN CHAPTER 5).

   ii) THE PROVISION BY THE OWNER/OPERATOR OF SERVICES THAT MEET STANDARDS SPECIFIED IN THE CONTRACT (FOR DETAILS SEE SCHEDULE B OF THE DRAFT PROTOTYPE CONTRACT IN CHAPTER 5);

3) THE REQUIREMENT THAT THE OWNER/OPERATOR OF THE PROPERTY IN QUESTION ENTER INTO AN AGREEMENT WITH A SERVICE AGENCY WHICH IS RECOGNIZED AND APPROVED BY THE CITY AND THE PROVINCE AND IS IN RECEIPT OF FUNDING FROM THE MENTAL HEALTH COMMUNITY PROGRAM OF THE MINISTRY OF HEALTH TO ENSURE THE PROVISION OF AFTERCARE PROGRAMS ON THE PREMISES IN QUESTION.

RECOMMENDATION #4: THAT THE C.A.P. BE ADMINISTERED BY AN IMPLEMENTATION COMMITTEE TO COMPRISE CITY, METRO AND PROVINCE REPRESENTATIVES WHOSE RESPONSIBILITIES WILL INCLUDE:

a) DEVELOPMENT OF A HIGH QUALITY INTERIM RESIDENTIAL FACILITY TO BE PUT IN PLACE PRIOR TO THE REPAIR OF ANY CONTRACT HOUSE TO BE AVAILABLE TO TENANTS WHO MAY BE DISPLACED DURING REPAIRS;

b) SELECTION BY PROPOSAL CALL OF THE CONTRACT HOUSES FOR THE PROJECT;

c) THE ADMINISTRATION OF THE CONTRACTS AND AGREEMENTS REFERRED TO IN RECOMMENDATION 3 AND THE IDENTIFICATION AND DIRECTION OF CITY STAFF TO CARRY OUT THE INSPECTION AND MONITORING OF THE CONTRACT HOUSES;

d) THE UNDERTAKING OF ANNUAL REVIEWS AND THE RECOMMENDATION OF CONTRACT RENEWALS TO CITY COUNCIL;

e) ENSURING THAT PRIORITY OF TENANCY IN THE UPGRADED CONTRACT HOUSES BE GIVEN TO THOSE WHO RESIDED IN THE HOUSE AT THE TIME THE CONTRACT WITH THE CITY WAS SIGNED.

RECOMMENDATION #5: THAT THE GOVERNMENT OF ONTARIO AMEND THE LANDLORD AND TENANT ACT SO THAT IT IS CLEAR THAT ITS PROVISIONS APPLY TO OCCUPANTS OF ROOMING AND BOARDING HOUSES.

RECOMMENDATION #6: THAT THE MINISTRY OF CONSUMER AND COMMERCIAL RELATIONS UNDERTAKE TO DEVELOP PROVISIONS IN THE LANDLORD AND TENANT ACT TO DEAL WITH PROBLEMS UNIQUE TO ROOMING AND BOARDING HOUSES SUCH AS THE QUALITY OF SERVICES SUPPLIED.

RECOMMENDATION #7: THAT THE GOVERNMENT OF ONTARIO UNDERTAKE THROUGH THE ESTABLISHMENT OF AN INTERMINISTERIAL COMMITTEE, A REVIEW OF THE LEGAL STATUS OF TENANTS IN THE SUPPORTIVE HOUSING SECTOR. THIS REVIEW SHOULD BE DONE IN CONSULTATION WITH DISCHARGED PSYCHIATRIC PATIENTS, COMMUNITY WORKERS AND OTHER SERVICE PROVIDERS ABLE TO PROVIDE THE INTERMINISTERIAL COMMITTEE WITH ESSENTIAL PRACTICAL KNOWLEDGE NOT OTHERWISE AVAILABLE, WITH A VIEW TO ENSURING THAT THESE TENANTS ARE AFFORDED APPROPRIATE PROTECTION COMMENSURATE WITH THE UNIQUE AGENCY/RESIDENT RELATIONSHIP IN SUPPORTIVE HOUSING.

RECOMMENDATION #8: THAT A TORONTO COMMUNITY CRISIS CENTRE BE SET UP ALONG THE FOLLOWING LINES:

1. THIS IS A CRISIS CENTRE: IN GENERAL, LENGTH OF STAY TO BE LESS THAN 7 DAYS. THE OBJECTIVE IS TO HELP A PERSON IN PSYCHIATRIC CRISIS TO BECOME SUFFICIENTLY STABILIZED SO THAT HE OR SHE CAN RETURN TO THE COMMUNITY WITHOUT INAPPROPRIATE HOSPITALIZATION. METHODS WILL INCLUDE SHORT-TERM SUPPORTIVE COUNSELLING; EFFECTIVE REFERRAL LINKS; CONCRETE ASSISTANCE WITH IMMEDIATE CRISIS RELATED PROBLEMS; ACCESS TO SELF-HELP SUPPORT OR COUNSELLING WHERE APPROPRIATE; MEDICATION WHERE APPROPRIATE. METHODS WILL NOT INCLUDE FORCED MEDICATION. THE EXPECTATION IS OF A SPEEDY RETURN TO THE COMMUNITY.

2. THE TARGET CLIENTS ARE CHRONICALLY PSYCHIATRICALLY DISABLED PERSONS IN CRISIS WHO LACK SUPPORTIVE RESOURCES. THE CENTRE IS NOT DESIGNED FOR INVOLUNTARY CLIENTS. INITIALLY IT IS ANTICIPATED THAT WITHIN THESE PARAMETERS ADMISSION CRITERIA MUST BE FLEXIBLE. THE CENTRE SHOULD STRIVE TO AVOID A TOO RESTRICTIVE APPLICATION OF "CHRONICALLY PSYCHIATRICALLY DISABLED". AT THE SAME TIME, THE TARGET IS PSYCHIATRIC CRISES OF A CHRONIC NATURE - THOSE WHOSE NEEDS ARE DEMONSTRABLY NEGLECTED - AND THE ORIGINAL MANDATE SHOULD NOT BE DILUTED.

3. A FREE-STANDING CENTRE LOCATED IN A RESIDENTIAL HOUSE IN DOWNTOWN TORONTO.

4. FIFTEEN BEDS BE AVAILABLE IN A COMFORTABLE, NON-INSTITUTIONAL ENVIRONMENT.

5. THE HOURS OF OPERATION BE 7 DAYS PER WEEK 24 HOURS PER DAY, HOLIDAYS AND WEEKENDS INCLUDED.

6. FUNDING FROM MINISTRY OF HEALTH, COMMUNITY HEALTH PROGRAMS BRANCH. ESTIMATED START-UP COSTS $644,800. ANNUAL COST $500,000. SEE APPENDIX C

7. CRISIS CENTRE TO BE OPERATED AND MANAGED BY A COMMUNITY BOARD RESPONSIBLE TO THE CITY OF TORONTO AND THE MINISTRY OF HEALTH. PREDECESSOR TO THIS BOARD SHOULD BE A GROUP CONSIDERING THE DETAILED IMPLEMENTATION. THIS GROUP SHOULD INCLUDE LOCAL RESIDENTS, SERVICE CONSUMERS, SUPPORTIVE HOUSING COALITION SUB-COMMITTEE ON CRISIS CARE.

8. MANDATE TO BE REVIEWED AFTER THREE YEARS OF OPERATION. EVALUATION TO BE BASED ON THE NUMBER OF CLIENTS SERVED, ENDORSEMENT FROM PSYCHIATRIC AFTERCARE PROVIDERS AND CONSUMERS, STAFF ASSESSMENT, BOARD.

9. QUALITY OF STAFF CRITICAL TO EFFECTIVE OPERATION. CENTRE STAFF TO INCLUDE MEDICALLY TRAINED AND COMMUNITY TRAINED MENTAL HEALTH CARE WORKERS. FOLLOWING VANCOUVER VENTURE HOUSE MODEL:

    1 COORDINATOR/DIRECTOR.
    9 CLINICAL STAFF (REGISTERED NURSES, REGISTERED PSYCHIATRIC NURSES, PUBLIC HEALTH NURSES, OR PSYCHIATRIC SOCIAL WORKERS.)
    3 COMMUNITY MENTAL HEALTH CARE WORKERS.
    1 COOK.
    1 SECRETARY.
    PLUS RELIEF STAFF. 3 STAFF ON DUTY AT ALL TIMES.

10. PSYCHIATRISTS AND MEDICAL STAFF TO BE SECONDED ON A ROTATING BASIS FROM THE GENERAL HOSPITALS, ESPECIALLY THE TEACHING HOSPITALS. ONE PSYCHIATRIST ON CALL FOR MEDICAL EMERGENCIES,

POSSIBLE ADMISSION TO HOSPITAL, AND PRESCRIPTION OF MEDICATION.

11. STRONG LINKS BE FORGED WITH THE GENERAL HOSPITAL EMERGENCY DEPARTMENTS AND PSYCHIATRIC WARDS AS WELL AS CASE MANAGERS. CENTRE IS INTENDED TO BE FREE-STANDING, AN ALTERNATIVE STEP, BUT NOT ISOLATED FROM HOSPITAL OR COMMUNITY.

12. EFFECTIVE REFERRAL LINKS BE ESTABLISHED AND MAINTAINED TO AND FROM COMMUNITY SERVICES. A CENTRAL OBJECTIVE IN EARLY STAGES OF THE PROGRAM TO BE LIAISON WITH POTENTIAL USERS OF THE SERVICE - HOSTELS, CONSUMER GROUPS, POLICE, BOARDING HOME OPERATORS AND FAMILIES.

13. PART OF PRELIMINARY PROCESS TO INCLUDE EXTENSIVE TRAINING FOR STAFF WITH A VIEW TO GAINING AWARENESS OF SERVICES AVAILABLE AS DETAILED IN DISTRICT HEALTH COUNCIL INVENTORY OF MENTAL HEALTH SERVICES IN METRO. SIMILARLY, A VITAL EARLY TASK IS FOR CRISIS CENTRE STAFF TO EDUCATE SERVICE PROVIDERS AND COMMUNITY RESOURCE GROUPS ON THE CENTRE'S ROLE.

14. FROM THE INCEPTION OF THE PROGRAM A LEASED CAR AND AT LEAST ONE STAFF MEMBER BE AVAILABLE FOR MOBILE COMMUNITY PROGRAM INTERVENTION.

15. IN THE SECOND YEAR OF OPERATION, A DISTRESS LINE BE ADDED TO THE SERVICE. INITIALLY, THE 911 EMERGENCY NUMBER FOR REFERRALS SHOULD BE ENCOURAGED. THE "HOTLINE" SEEMS PARTICULARLY VALUABLE IN VIEW OF THE VANCOUVER EXPERIENCE WHERE MANY PROBLEMS THAT CAN TURN INTO EMERGENCIES - FOR EXAMPLE, UNCERTAINTY ABOUT MEDICATION - CAN BE FORESTALLED ON THE PHONE. LIAISON WITH GENERAL DISTRESS LINES NOW IN OPERATION SHOULD FIRST BE UNDERTAKEN.

RECOMMENDATION #9: THAT THE GENERAL HOSPITALS IN THE CITY OF TORONTO SERIOUSLY CONSIDER THE ESTABLISHMENT OF CRISIS INTERVENTION TEAMS BASED ON THE MODEL THAT HAS BEEN DEVELOPED AT THE MISSISSAUGA HOSPITAL.

RECOMMENDATION #10: THAT THE MINISTRY OF HEALTH SERIOUSLY CONSIDER INCREASING FUNDING FOR EXTENSION OF HOURS AT AFTERCARE SERVICES USED BY DISCHARGED PSYCHIATRIC PATIENTS IN CRISIS, SUCH AS THE SATELLITE CLINICS OF THE QUEEN STREET MENTAL HEALTH CENTRE, THE PARKDALE ACTIVITY AND RECREATION CENTRE AND SOME PROGRAMS RUN BY SELF-HELP GROUPS.

RECOMMENDATION #11: THAT THE PARKDALE MENTAL HEALTH CO-ORDINATION SERVICE BE ENDORSED IN PRINCIPLE BY THE CITY OF TORONTO, PROVIDED THAT THE INITIAL STAGE OF THE SERVICE MUST BE THAT OF EXTENSIVE CONSULTATION WITH THE AGENCIES, INCLUDING HOSPITALS AND THE QUEEN STREET MENTAL HEALTH CENTRE, WITH A PARTICULAR EMPHASIS BEING

PLACED ON CONSULTING WITH CONSUMERS OF MENTAL HEALTH SERVICES IN THE PARKDALE AREA.

3. THE HISTORICAL CONTEXT: PERSPECTIVES ON MENTAL HEALTH AND ILLNESS

In Canada, as elsewhere, the dilemma of how best to care for the chronic mentally ill person* has a lengthy history. Over the course of centuries, passionate advocates have proposed as well as practiced reforms which seemed radical in their day, but are now dismissed as barbaric. Changing conceptions of madness and ideas about appropriate treatment for it reflect broad cultural, political and economic biases. Despite the fact that proposed "solutions" have undergone dramatic changes throughout the years, the dilemma of how best to care for the chronic mentally ill stubbornly persists. Typically, the chronic mental patient has been the one to fall through the service gap created when performance has not lived up to promise in the psychiatric field. The fault was rarely in the reformer's intention. The concerned citizens, professionals and mental health service consumers of the 1980's, like their predecessors, are motivated by a profound awareness of the problems and a desire to find solutions. It is rather humbling to examine the record of experimentation in this area; nonetheless, it is useful to take a second look before proceeding with proposals.

What began approximately 20 years ago as enthusiasm for the idea of discharging people with chronic psychiatric illnesses from mental institutions into the community, has evolved into sober reappraisal of the often tragic consequences of inadequate follow-through with these people.[2] The policy of "de-institutionalization" has too often been accompanied by a serious lack of the community resources needed to replace institutional care. The lives of those now subsisting in Toronto's transient hostels and boarding homes document this failure in planning, and will be addressed in the following sections of the Report. It is worth taking a moment to examine the roots of the concerns which led to this Task Force in order to provide a context for the Report.

* We have defined for the purposes of this report the chronic mentally ill person as "an adult who has persistent disabilities associated with a major psychiatric disorder".[1]

In Western feudal society, the non-disruptive mentally ill were cared for in the community, primarily by family and religious institutions. Madness was considered a form of demonic possession, sometimes calling for exorcism or death. But with the decline of church influence, secular views took hold. During the 16th and 17th centuries, the insane were seen as threats to society, along with cripples, the poor, and other "deviants".

The accepted solution for dealing with these people was to lock them away, often in chains. Humane concerns surfaced as part of the Enlightenment in the 18th century, and mental health pioneers (like Pinel in France, and Tuke in Great Britain), tried to develop institutions designed specifically to care for the mentally disabled. Their successes inspired 19th century reformers in Europe and North America to call for the construction of publicly-supported asylums. American crusader Dorothea Dix promoted the idea of "moral treatment", a belief that humane surroundings and staff could cure mental illness. Earlier, Ontario (then Upper Canada) had opened its first asylum in Toronto (then York), by converting a former jail. The Canadian provinces were handed responsibility for the care of the mentally ill at the time of Confederation in 1867.

By the early 20th century, appalling conditions in many of the mental institutions ("snake-pits") again produced calls for reform. Canada was caught up in the general North American awareness of mental health issues such as custody versus caring. Especially influential was the publication in the early 1900s of Clifford Beers' book A Mind That Found Itself. A recovered patient, Beers exposed the horrendous conditions inside the mental institutions where he had been confined. At the same time, Adolf Meyer was espousing a familiar sounding public health program emphasizing the contribution of the social environment to mental illness, and its championing of a coordinated program of prevention, treatment and aftercare. Together, Meyer and Beers initiated the Committee for Mental Hygiene (a forerunner of the community mental health movement).

In Canada, Dr. Clarence Hincks, founder of the Canadian Mental Health Association (1918), travelled from one end of the country to the other, documenting the deficiencies in mental health care. During World War Two, the high rates of mental illness detected by Canadian Armed Forces screening procedures led to public awareness of the prevalence of mental illness in the population at large. After the war, the Federal Government took steps to upgrade the mental institutions, and from 1949 to 1959 there was an increase of almost 18,000 in bed capacity.

But in the 1960's, two major developments hastened the acceptance of the idea of community mental health. First, information became available from government reports and social/scientific studies that documented the failure of large institutions to cure mental

illness. Some authors (for example, Erving Goffman) suggested that incarceration in hospital made matters much worse for the patient.

Second, the discovery of psychotropic drugs raised the hope that properly-medicated patients could be stabilized and released into the community. The introduction of Canada's comprehensive medicare program in the late 1960's further supported the reasoning that appropriate care could be made available outside institutions. As a result, the idea of community mental health flourished.

Although support mechanisms for ex-patients in the community grew at a very slow pace, the discharge of patients from the institutions accelerated. From 1965 to 1976, the total number of patients in Ontario mental hospitals dropped by 75%. However, admission rates doubled, and discharges almost tripled. Re-admissions constituted two-thirds of all admissions. At least in theory, the approach in Ontario was to integrate psychiatric services with public health services. Part of the plan was to establish psychiatric units in the general hospitals, complemented by a variety of out-patient clinics. But, as will be evident in greater detail in the next section, the gap between theory and practice in deinstitutionalization experiments was great. Resources in the community were under-funded and sometimes non-existent. Once again, cries for reform were heard.

When it became clear that deinstitutionalization had not delivered all it had promised, disillusionment set in. Advocates from the community mental health movement had based their reforms on certain operating assumptions, and the validity of these assumptions now came under attack. Illustrative of this trend - which began in the U.S. - was a 1978 article in "Scientific American" that posed the question: "Does deinstitutionalization represent an enlightened revolution or an abdication of responsibility?" In their examination of "how such a well-intentioned reform as deinstutionalization could have created so many problems", the authors called attention to the fact that people with chronic psychiatric disabilities were being neglected. This theme has been taken up by many other observers - by those who attack the community model as simplistic, and by those who defend it as an imperfect version of worthwhile objectives. John Talbott, for example, is a staunch defender of the community model, based on his comparative studies that show that patients provided with adequate after care in the community fare better in a number of ways than those treated in hospital. However, Talbott agrees that one result of deinstitutionalization was that "often the sickest patients were not receiving their share of attention".

Nonetheless, Talbott and others warn against the "throwing the baby out with the bath water" phenomenon: He suggests that more community resources and better integration of service might provide further solutions.

In the same vein, but on a more pessimistic note, are two recent reports: 1) Community Psychiatry: A Reappraisal by the prestigious Group for the Advancement of Psychiatry, and 2) Caring for Mentally Ill People, a recent book by Alexander Leighton. Dr. Leighton, now Professor of Psychiatry and Preventive Medicine at Dalhousie University, identifies what he calls four barriers to effective mental health care:

1. "Heterogeneity of the field is not appreciated by many of the protagonists." In other words, use of the term "mental illness" disguises the diversity of the population.

2. "The emotions generated by the topic of mental illness tend to confuse most issues." Most observers feel dread and awe.

3. "There is a failure to stick to scientific procedures and facts as the basis for action." Political rhetoric is substituted for 'scientific' evaluation of outcomes.

4. "Too many goals and too few priorities continue to be articulated." From prevention, to public education, to care for the chronically ill - these comprehensive goals may defeat the achievement of even limited goals.

Dr. Leighton, formerly a leading proponent of community psychiatry, grounds his disillusionment on the experience of 21 years of overseeing (from a distance) a rural community mental health centre in Nova Scotia. In particular, he challenges commonly used, but rarely defined, terms like "mental illness", "mental health", and "community". He argues that many of the problems arising from the movement toward providing mental health care in the community result from the fact that it is difficult to plan good care when the assumptions we are operating on are undefined, and possibly undefinable. He draws a critical distinction: "policies in mental illness care, like other policies, are determined by opinion, whereas outcomes are determined by realities. The challenge is to find ways and means for bringing opinions and realities closer together." Like Leighton, the Group for the Advancement of Psychiatry (G.A.P.) voices concern over the current outcome of the community psychiatry movement. In their report on community psychiatry, G.A.P. identifies nine major assumptions behind the community mental health movement:

1. Care in the community is less expensive than care in hospital.

2. Care in the community is better than care in hospital.

3. Comprehensive care is desirable and a necessary goal that can be achieved in the community.

4. Continuity of care is beneficial.

5. Designation of catchment areas enhances provision of services.

6. Accessibility to mental health services is essential.

7. Social environment produces mental illness.

8. Preventive efforts can reduce the incidence and prevalence of mental illnesses.

9. Local responsibility and control are necessary to ensure the success of community mental health.

Leighton, whose views are almost identical to those of G.A.P., questions these assumptions and concludes that psychiatry in general and the community mental health movement in particular, suffers from not having "an adequate, generally accepted frame of reference for dealing with mental illnesses".

In Canada, the Clarke Institute of Psychiatry Consulting Group provides a noteworthy exception to some of the criticisms raised by Dr. Leighton. In two studies, "Psychiatric Aftercare in Metropolitan Toronto," and the "Southern Alberta Study of Psychiatric Needs and Provisions," the consulting group manages to combine a concern for urgent problems with an awareness of theory and methods. It is certainly incorrect to say that serious research and evaluation is not taking place on the practise of community mental health care. For example, the Greater Vancouver Mental Health Services Evaluation and Research Department is collaborating with the Department of Psychiatry at the University of British Columbia and the University of Oregon at Portland, Oregon in a study on the impact of different community aftercare treatment systems on patient outcome. The Vancouver model, which will be discussed further in the next section of this report, has an extensive system of aftercare services. This coordinated service model is compared to the system in Portland, Oregon where there is virtually no aftercare available. The latter city serves as a "no treatment" locus of the study. Preliminary results show that the Vancouver patients who were followed after discharge from hospital had fewer hospitalizations following discharge and were more likely to be gainfully employed in the competitive market and leading fairly normal lives.[3]

While it is essential to address the valid points raised by critics of community mental health as it has developed, attention must be paid to those people who continue to work to improve the community mental health care delivery. Dr. John Wing, a prominent English psychiatrist, leaves us with this thought: "The idea, the vision, of 'community care' is not enough. It must be backed by hard, realistic planning and adequate resources. The vision can still be realized".

FOOTNOTES:

1. Clarke Institute of Psychiatry Consulting Group. Consultation Report: Systems Coordination for Psychiatric Services in Toronto, June 7, 1983.

2. This account is based on the following sources:

   Ellen Bassuk & Samuel Gerson, "Deinstitutionalization and Mental Health Services", Scientific American, February, 1978.

   Consulting Group, Clarke Institute of Psychiatry, extract from the "Southern Alberta Study of Psychiatric Needs and Provisions", Part 2, Current Concepts in Psychiatric Care: The Theoretical Basis of Our Recommendations. January, 1983.

   M. J. Dear & S. M. Taylor, not on our street, Pion Limited, 1982.

   Group for the Advancement of Psychiatry, Committee on Psychiatry and Community. Community Psychiatry: A Re-appraisal, Mental Health Materials Centre, 1983.

   Charles Kiesler, "Public and Professional Myths About Mental Hospitalization", American Psychologist, December 1982.

   Alexander H. Leighton, Caring for Mentally Ill People, Cambridge University Press 1982.

   Steve Lurie, "More for the Mind, Have We Got Less?" November 1980.

   Queen Street Mental Health Centre Symposium on the Organization and Delivery of Mental Health Services. May 25, 1983.

      C. A. Roberts, "More For The Mind Twenty Years Later, The Canadian Experience".

      J. A. Talbott, "Trends In The Delivery Of Psychiatric Services".

      John K. Wing. "Community Care: Vision Theory and Practice".

3. Greater Vancouver Mental Health Service, 1982 Annual Report, p. 10-11. And personal communication with Ron Peters, GVMHS, Department of Evaluation and Research.

4. OVERVIEW OF THE TORONTO SITUATION

It should be noted that there was no financial allowance in the Task Force's budget for commissioning research. We proceeded on the understanding that not only had considerable research already been done, but that research was ongoing due to efforts by the Ministry of Health, the Metro District Health Council, and the Toronto Department of Public Health. For these reasons, the overview in this chapter represents an examination of the facts and proposals found in the articles and reports (referenced in the footnotes to this chapter), as well as information presented at our public hearings. The overriding questions raised from this examination process challenge us to determine how we can effectively alter the situation for the 5% of the population who have been diagnosed as chronically "mentally ill" and the 20% who suffer from serious, if temporary, psychiatric disorders.[1]

Certainly part of the answer could be found in the more equitable distribution of financial resources. For example 3.3% of the $6.8 billion provincial health care budget is allocated for community mental health services.[2] However, as will become evident from this report, targeting more money to this particular aspect of mental health care offers only a partial solution to the complex problems of discharged psychiatric patients and their reintegration into the community.

Hospitalization

During the past 20 years there has not only been a decrease in the psychiatric inpatient population, but there has also been a dramatic shift from using the large psychiatric provincial hospitals to the smaller psychiatric units of general hospitals (i.e. in 1960, 20,058 patients were housed within psychiatric hospitals with only 347 in the general psychiatric units. In 1976 4,654 patients were in psychiatric hospitals with 1,425 in the general hospital units).[3]

Despite the drastic cutbacks in psychiatric hospital beds, it is interesting to note that in 1979-80, Ontario spent $33 per capita on the hospital sector for 1% of the psychiatric population and $3 per capita on the community resources for 6.5% of the population.[4] During the same time period, a "Level of Care Study", conducted by the Whitby Psychiatric Hospital, revealed that 47% of the inpatients did not even require 24-hour hospital care. The Whitby nurses themselves estimated that as many as 78% of the patients were inappropriately hospitalized.

Queen Street Mental Health Centre (hereafter referred to as QSMHC) had 3,636 admissions in 1981-82. 67% of these were readmissions. Furthermore, 51.16% of those patients admitted were at the stage of their lives that is considered the most productive (ages 20-40).[5]

Discharge

In Metro Toronto there are hundreds of psychiatric patients discharged every month. In one study, 96% of those discharged were perceived by hospital staff as needing medical/therapeutic aftercare; only 82% received referrals.[6] Social/recreational needs were of such low priority that only 12% of the 43% of patients needing referrals as identified by staff actually obtained them. 23% of the patients had need of some sort of supportive housing; 10% were presented with referrals. The reasons for not referring a patient despite an obvious need were cited as: "patient not willing to accept referral" or "not a priority" or "patient to make own arrangements".

The above statistics indicate that hospital staff largely ignore the non-medical forms of aftercare. It was concluded that this underutilization of aftercare services continues to create "an important barrier to aftercare service delivery".[7]

Housing Shortages

A recent survey of QSMHC, the Clarke Institute of Psychiatry and 3 general hospitals undertaken in 1982 demonstrated that 20-30% of the discharges are delayed because proper accommodation is not available outside the institution.[8] The 1981 study by the Community Resources Consultants[9] revealed that: 23% of the original 774 subjects required some sort of supportive housing at the time of discharge. If we assume this sample to be representative then 3,220 of the annual 14,000 discharged psychiatric patients in Metro Toronto would be in need of housing referrals.[9]

In August 1981 there were 2,023 psychiatric beds in Metro Toronto but this figure had dropped by 202 since the previous August.[10] The majority of the beds are located in the area of the City of Toronto where approximately 58%of psychiatric clients live in boarding homes. In the northern region, where one finds the lowest concentration of psychiatric clients per caseload, and where 34% of the clients live with their families, there are next to no beds for ex-psychiatric patients.

Services for locating housing for former psychiatric patients report a dreadful "Catch 22" situation. The prospective tenant needs to obtain General Welfare Assistance (GWA) to pay the required rent deposits to a prospective landlord, and yet is unable to obtain GWA because the Municipality of Metropolitan Toronto as a general policy requires the person to have a "permanent address".[11] For a single, unemployable person, the maximum GWA is $288 per month and the minimum boarding house cost is $230 a month. Thus, at a minimum, approximately 90% of the individual's monthly income is consumed by the cost of room and board. A single disabled person receiving the family benefit allowance (FBA) of $364 per month may have the luxury of more spending money after rent payments, but the individual will still be forced to live on income that is below the poverty level. Unlike most other forms of rental housing, the rent charged in the majority of boarding homes is often geared to income, so that the FBA recipient usually pays more rent than the GWA recipient for the same accommodation (and usually food). As well, any financial increases granted GWA or FBA recipients are usually absorbed immediately by the landlord's raising the cost of room and board proportionate to the amount of increase, leaving the resident no further ahead.

In Metro Toronto, 18 hostels supply a total of 1,740 beds.[12] A one -night survey on April 6, 1982 revealed that 17% of the residents had either a past or probable psychiatric history. Following a recently conducted study, Nellie's Hostel reported[13] that as many as 40% of their residents had recent psychiatric histories and 57% of the women lacked any source of income. Ninety-five% of the women in the study were in need of a greater level of supportive care than that which was available at Nellie's, but there was no alternative available. While one cannot conclude that a person with a "past or probable psychiatric history" is necessarily someone who is "chronically mentally ill", combined with the fact that these individuals were residing in emergency housing and that the percentage in need of supportive care was so high, we feel these figures are indicative of an unmet need.

Even hostels cannot always guarantee accommodation for ex-psychiatric patients. According to the "Housing Gap" study,[14] most of the hostels have developed "barred lists" or "caution alert" lists. This study's examination of the lists of 6 hostels revealed that 68% of the persons on their "barred lists" and 67% of the people on the "caution alert" lists had psychiatric histories. Hostel staff stated that their own inadequate training and insufficient numbers made it very difficult to handle a resident in crisis. Furthermore, hospitals' reluctance to admit residents who have disrupted the hostel due to psychiatric problems has proven to be a regular source of frustration for hostel staff.

The Supportive Housing Coalition contends that a definite correlation exists between squalid housing and the exacerbation of a patient's condition, but it is difficult to support this contention with exact figures. Diane Capponi, a discharged psychiatric patient who spoke at the Task Force hearing held in Parkdale, stated that, "More than likely you are going to end up back at Queen Street, not because of the problems that originally put you into Queen Street, but because of the problems that you have to face in a boarding house. It's just a terrifying horror story".[15]

Housing Options

The Supportive Housing Coalition has clearly identified the need for a wide spectrum of supportive housing models which would offer anything from 24-hour supervision to weekly support and on-call supervision.[16] To reach these objectives, in 1981 they recommended that an additional 270 housing alternative beds be funded and that a mandated agency organize enrichment services to boarding homes and hostels. In response to representations from the Supportive Housing Coalition and others, the Ministry of Health has approved funding for approximately 190 beds. At the present time, the Supportive Housing Coalition, in conjunction with other community agencies and groups, is in the process of developing alternative community housing operations which combine the available funded beds with appropriate support services.

1) Alternative Community Housing (Non-Profit)

A. Cooperative Housing

Houselink Community Homes is an example of a non-profit housing project which operates more than a dozen co-ed and cooperative apartments and houses throughout Metro Toronto.[18] Each home accommodates four or five people and as there are no live-in staff, the residents must establish their own house rules, pay their own rent, etc. Houselink's goal is to keep the housing affordable at $89 to $145 per person per month, (rent, not board). However, housing price increases and "exclusionary" zoning by-laws have made this increasingly difficult. The project is not classified under group home by-laws in most municipalities, but is funded instead by the Ministry of Health under the Community Mental Health Program. Recently, Houselink has been granted a loan from Canada Mortgage and Housing Corporation to purchase a new house. The Ministry of Housing has committed itself to subsidizing the rent in this particular home.

Studies have shown that residents who benefit from these forms of "high expectations" halfway houses achieve a greater level of vocational and social functioning when

compared to control groups living in boarding houses.[19], [20], [21] The average Houselink resident has been described to us as being 30 years old, non-transient, with a secondary or post-secondary education. This profile does not describe a great number of the people living in boarding houses in Toronto, many of whom may not yet have the aptitude to adjust well to an enriched program such as Houselink.

B. Group Homes

Although this is the term most often used to describe a particular form of high support housing, the technical term used by the City of Toronto in its zoning by-law is "residential care facility".

The province has developed this definition of a group home:

> ... a single housekeeping unit in a residential dwelling in which three to ten unrelated residents live as a family under responsible supervision consistent with the requirements of its residents. The home is licensed or approved under Provincial Statute in compliance with municipal by-laws.[22]

At the present time, however, it is the policy of the Government of Ontario not to "legislate" group homes. The policy is one of "... encouraging (but not requiring) municipalities to amend their official plans and zoning by-laws to permit group homes in all residential areas without the need for site-specific amendments." (Ontario Group Homes Resource Manual, Secretariat for Social Development.) To quote the former Provincial Secretary for Social Development, Margaret Birch: "The philosophy and the intent of this government is to achieve our objectives through co-operation with municipalities."[23]

The Metropolitan Toronto Council adopted an official plan for group homes on June 8, 1979 (approved by the Minister of Municipal Affairs and Housing on April 16, 1981) which recommended that the municipalities should permit residential care facilities through as-of-right zoning.[24] The Metropolitan Council reaffirmed this policy of requiring a Metro-wide distribution of group homes on April 14, 1982 and again on May 10, 1983. Objections by certain municipalities have been lodged with the Ontario Municipal Board, but no hearings have yet taken place.

Until the Ontario Municipal Board makes its decision, the existing disparity among the various boroughs and cities

which constitute Metropolitan Toronto in respect to group homes by-laws will continue to be substantial. For example, North York has a group home by-law which specifies distancing factors, permits only single detached homes to be utilized and stipulates that the number of residents be 3 - 10. The Supportive Housing Coalition[25] argues that this by-law prevents those who do not require large home accommodation with 24-hour supervision, from living in 3 - 5 person units of close proximity with shared supervision.

The City of Toronto, which passed a group home by-law in 1978, "has one of the most progressive and supportive group home policies of any North American city ... the City of Toronto stands alone with its policy of permitting all types of group homes in all residential districts with minimal restrictions".[26]

2) Boarding Homes

The Municipal Act (R.S.O., 1980, Chapter 379, Section 46) allows for but does not mandate municipal licensing, regulation and inspection of "boarding homes", per se. A 1980 report recommended that the authority for licensing and regulation could be delegated, under this Act, to the local Boards of Health, but additional municipal by-laws would be required.[27]

Municipalities in Ontario regulate boarding homes to differing degrees, and this has led to uneven development and concentration of residential facilities.[28]

Within Metro Toronto the number of available "recommended" beds has decreased from 480 in 1979 to 384 in 1982.[29] Only 2 municipalities in Metro permit licensed boarding homes - Etobicoke and the City of Toronto - and their by-laws control the physical standards but not the quality of service or care.

As of April 1, 1981 a new licensing by-law in the City of Hamilton recognized second-level lodging houses. These facilities: have 4 or more residents; provide operators who, for a fee, offer counselling on activities of daily living and provide 24-hour supervision; comply with building, fire and safety regulations. There has been a policy decision (by the Regional Municipality of Hamilton-Wentworth) to establish contracts with operators of certain of the "second-level lodging houses" providing financial assistance (domicilliary hostel funds) to those operators who maintain a defined standard of care as per the by-law and the individualized contract. Approximately half of the residents in these contract homes are discharged psychiatric patients.

In the City of Hamilton, 27 "second-level lodging homes" are referred to as contract lodging homes, i.e. operators must provide 24-hour supervision, monitor residents' medication intake etc.,[30] but programming is not required of these licensed boarding homes.

Social Planning and Research Council of Hamilton, Report, Task Force on Lodging Houses, August 1981.

3) Approved Homes and Homes for Special Care

The Approved Homes Program functions under the Mental Hospital Act and is administered by the local provincial psychiatric hospital. The program is intended to provide short-term, transitional support to in-patients who are soon to be discharged from the hospital. The number of Approved Home beds is steadily decreasing. The Community Resources Consultants' study[31] reported that 135 Approved Home beds existed in Metropolitan Toronto in 1974 while in 1982 there were only 43 beds in Metro Toronto. Today, there exists a total of 25 Approved Home beds within the City of Toronto; 13 of these are QSMHC beds and 12 are Whitby Hospital beds. Another 11 Whitby beds are in the planning stages. (Marie Chapeskie, Community Resources Consultants of Toronto, Pers. Comm., August 4, 1983).

Homes for Special Care come under the legislative authority of the Homes for Special Care Act (1964).[32] These homes, which are classified as either "residential" or "nursing", are licensed annually by the Province, are in compliance with municipal by-laws but are inspected by the Province. Their mandate is to provide long-term stable housing with 24-hour supervision and care as required. The homes come under the jurisdiction of the sponsoring provincial hospital and in the case of Metro Toronto, which is served by two provincial hospitals, the majority of H.S.C. beds are located outside Metro's boundaries. The most recent figures show that within the City of Toronto there are 50 "residential" beds (26 from QSMHC and 24 from Whitby) and 75 "nursing" beds. (Marie Chapeskie, C.R.C.T., Pers. Comm., August 4, 1983).

Psychiatric Aftercare Service

The Metropolitan District Health Council has reported that a comprehensive mental health service would consist of the following:[33]

Hospitalization
Discharge Planning
Coordination
Data Development

Partial Hospitalization
Day Treatment
Outpatient Treatment
Crisis Intervention
Continuity of Care
Cooperation
Supportive Housing
Financial Assistance
Vocational Training
Social/Recreational Programs
Case Management

The aftercare components of this model have been researched extensively and changes have been ongoing for at least the past year. During the course of this Task Force, many of these program changes have moved from the theoretical to the practical. Further comments will be made in the Aftercare chapter of this report.

The Community Resources Consultants of Toronto are designed to be a "service for services".[33] C.R.C.T. also provides community rehabilitation services. This program employs 3 1/2 Rehabilitation Specialists and 4 Rehabilitation Assistants whose job is to devise a community support network for their clients.[34]

The idea of Rehabilitation Specialists is not unique to the C.R.C.T. In September 1982, the Clarke Institute of Psychiatry Consulting Group recommended that 10 case managers be added to the existing staff of the satellite clinic, Archway, in order to follow clients on a long-term basis.[35] The Heseltine report, "Blueprint for Change: The Next Ten Years" also recommended the use of case managers.[36]

As an outcome of these 2 reports, the Ministry of Health was to have arranged funding for a team coordinator plus 10 case managers and support staff to supplement the Archway staff.[37] To date, the Team Coordinator has been employed and the hiring of the 10 case managers is almost complete.

Concern over the lack of coordination of mental health services has resulted in several studies which are still in progress. The Metropolitan Toronto District Health Council is conducting a study on coordination and crisis intervention which is expected to be completed by mid-1984.[39] Meanwhile, on June 7, 1983, the Clarke Institute of Psychiatry Consulting Group presented their first draft of a report entitled "Consultation Report: Systems Coordination for Psychiatric Services in Toronto"[40] to the Parkdale Working Group, convened by the Ministry of Health. Ironically, as the Consulting Group notes, the independent initiation of two studies on the same topic (three, if we include this Task Force) demonstrates perfectly the lack of coordination at all levels. Subsequent links have been made between these separate groups, nevertheless, "the fact remains that if a system for coordination already had been in place, perhaps a more collaborative, global approach to planning might have been possible from the outset". (p. 18).

Although many studies call for better coordination and linkages of services, the "Consultation Report on Systems Coordination for Psychiatric Services in Toronto" is unique in that it actually describes a working model for coordination and outlines the steps required to implement this model.[41] It is believed that the addition of ten new case managers to Archway's program must go hand in hand with a system of interagency coordination. The consultation report recommended that the Mental Health Division of the Ministry of Health considers the development of a pilot project which will integrate services for ex-psychiatric patients residing in Parkdale (and other parts of what the City's Department of Public Health calls the Western Health Area). It is possible for such a pilot project to be expanded to serve the City of Toronto's Public Health Department and to ultimately become a Metro-wide mechanism of coordinated services for all ex-psychiatric patients. The consultation report recommended that the funding for the pilot project be provided by the Ministry of Health and administered through the Toronto Department of Public Health. There would be regular and direct reporting from the project staff to the Medical Officer of Health and to a designate of the Ministry. Further commentary on this model can be found in the Aftercare chapter of this report.

The study by the Supportive Housing Coalition and the Department of Public Health, entitled the "Housing Gap",[42] recommends that the Ministry of Health should: provide funding for a comprehensive range of supportive housing; establish a 24-hour crisis team with a 15-bed crisis facility for those who are experiencing difficulties coping with their present residence; initiate a system to collect and monitor information on patients' housing situations, both pre-admission and post-discharge. The report further suggests that the Metro Toronto Community Services Department should increase the present allowance rates and remove the "Catch 22" which prevents someone without housing from receiving G.W.A. and someone without income (G.W.A.) from being able to obtain housing.

Underlying all of these issues in aftercare planning is the problem of income for ex-psychiatric patients. Unfortunately, as noted by the C.R.C.T. study,[43] "financial management is relatively neglected as an important component of aftercare". To focus solely on the housing that ex-psychiatric patients live in is to ignore the monetary reasons for their living in such impoverished surroundings. The "Housing Gap" report does recommend that the Metro Toronto Community Services Department increase the allowance rates. The Metro Toronto Community Services and Housing Committee in turn recommends that the Ministry of Community and Social Services and the Ministry of Health ensure that psychiatrically disabled people receive income under the Family Benefits Act as opposed to General Welfare Assistance.[44] Recently, the Minister of Community and Social Services, Frank Drea, announced that certain recipients of FBA would receive an increase.

Income is also tied to employment. The Community Occupational Therapy Associates (C.O.T.A.) has found that a high percentage of ex-psychiatric patients are unemployed. Employers are not generally sympathetic to the plight of the psychiatric patient. Government incentive programs for the disabled tend to give priority to the physically disabled. There is a need for more creative employment programs which would allow for partial and/or shared employment for discharged psychiatric patients - another group with a disability.[43]

A REVIEW OF THE LITERATURE - FOOTNOTES

1. Extract from the Southern Alberta Study of Psychiatric Needs and Provisions, conducted by: Consulting Group, Clarke Institute of Psychiatry, Commissioned by: The Southern Alberta Psychiatric Services Committee, January 1983.

2. Remarks by the Honourable Larry Grossman, then the provincial Minister of Health, to the Minister's Policy Conference, Health Care in the 80's and Beyond, April 24, 1983.

3. Statement by the Honourable Larry Grossman to the Standing Committee on Social Development, Concerning Blueprint for Change: The Next 10 Years, January 24, 1983.

4. Richman, A., Heseltine, G. and Roberts, P. Background Paper on the Future Development of Whitby Psychiatric Hospital, August 1982.

5. Queen Street Mental Health Centre, Facts and Figures, April 1, 1981 - March 31, 1982.

6. Community Resources Consultants of Toronto, Social and Community Psychiatry Section - Clarke Institute of Psychiatry, Psychiatric Aftercare in Metropolitan Toronto, April 1981.

7. Ibid, p. 20.

8. The Housing Gap: Deficiencies in Appropriate Housing for Ex-Psychiatric Patients, Joint Study for the City of Toronto Department of Public Health and Supportive Housing Coalition, May 1982.

9. See, Reference No. 6.

10. Supportive Housing Coalition, Community Housing for Consumers of Mental Health Services in Metropolitan Toronto, A Position Paper, September, 1981.

11. See, Reference No. 8.

12. Ibid.

13. Guyton, A. Research Committee, Nellie's Hostel for Women, The Role of Nellie's in Providing Psychiatric Aftercare, May 1982.

14. See, Reference No. 8.

15. Grant, R. "Boarding Houses are not the Answer, an Interview with Diane Capponi", Phoenix Rising, Nov. 1982, Vol. 3(2), p. 10-12.

16. See, Reference No. 10.

17. See, Reference No. 8.

18. Campbell, S. "Houselink Homes Need Volunteers", Toronto Star, March 19, 1983.

19. Houselink Community Homes, Research Project Report, January 31, 1981.

20. Lamb, R. and Goertzel, V. "High Expectations of Long-Term Ex-State Hospital Patients", Amer. J. Psychiatry, Vol. 129(4), Oct. 1971, pp. 131-135.

21. Wilder, J., Kessel, M. and Caulfield, S. "Follow-up of a 'High Expectations' Halfway House", Amer. J. of Psychiat., Vol. 124(8), February 1968, pp. 103-109.

22. Polak, M.E., Group Homes and Adult Community Mental Health Facilities in Metropolitan Toronto (unpublished).

23. The Social Planning and Research Council of Hamilton and District, Report from the Task Force on Lodging Homes, November 1981.

24. Municipality of Metropolitan Toronto, Report No. 8 of the Economic Development and Planning Committee, For Consideration by the Council of the Municipality of Metropolitan Toronto on May 10, 1983.

25. See, Reference No. 22.

26. See, Reference No. 24.

27. Metropolitan Toronto Social Services and Housing Committee Sub-Committee on Boarding Homes and Lodging Houses, Adult Residential Facilities, Boarding Homes and Lodging Houses, April 1980.

28. Orr, J. and Van Louwe, K. of the Social Planning and Research Council of Hamilton and District, Report on Zoning and Licensing of Residential Facilities in Hamilton-Wentworth, October 1981.

29. Community Resources Consultants of Toronto, Profile of Mental Health Housing Resources, 1982.

30. See, Reference No. 22.

31. See, Reference No. 39.

32. Metropolitan Toronto District Health Council, Discussion paper #1 & 2 for the Mental Health Care Committee of the Metropolitan Toronto D.H.C., January 1983.

33. Freeman, S., Fischer, L. and Sheldon, A. "An Agency Model for Developing and Coordinating Psychiatric Aftercare", Hospital and Community Psychiatry, Vol. 31(11), November 1980, pp. 768-771.

34. Community Resources Consultants of Toronto, Community Rehabilitation Services - C.R.C.T.

35. The Clarke Institute of Psychiatry Consulting Group (P. Goering - Principal Consultant) The Role of Archway in the Delivery of Psychiatric Service to Parkdale, September 10, 1982.

36. Heseltine, G.F. Interim Report, A Discussion Document, Blueprint for Change: The Next Ten Years, 1982.

37. Statement by the Honourable Larry Grossman to the Standing Committee on Social Development Concerning Blueprint for Change: The Next Ten Years, January 24, 1983.

38. Haller, M. (Archway staff), Personal Communication, July 4, 1983.

39. See, Reference No. 36.

40. Goering, P., Rodgers, J. Clarke Institute of Psychiatry Consulting Group, Consultation Report: Systems Coordination for Psychiatric Services in Toronto, June 7, 1983.

41. See, Reference No. 40.

42. See, Reference No. 8.

43. See, Reference No. 6.

44. See, Reference No. 27.

45. Diana Anderson, Mental Health Coordinator, COTA, speaking at the Advisory Committee Meeting of the Mayor's Action Task Force, July 12, 1983.

5. HOUSING

A review of the literature has revealed a serious shortage of affordable, appropriate accommodation for patients discharged into the community. The need has been extensively documented in a number of reports such as the Housing Gap (see footnote 8), Community Housing for Consumers of Mental Health Services in Metropolitan Toronto (see footnote 10), Adult Residential Facilities, Boarding Homes and Lodging Houses, (see footnote 27).

At the municipal level, problems associated with housing of discharged psychiatric patients have generated concern in the neighbourhoods which have of housing stock best adapted for use as "boarding homes". On several occasions over the years, this has been manifested as a political issue when residents of these neighbourhoods have directed their concerns toward "City Hall." A strong consensus seems to have developed that the most crucial step to be taken in resolving many of the "aftercare" issues is to improve the housing options available to the population of discharged psychiatric patients whose limited income effectively dictates their choice of low cost boarding homes (where meals are included in the rent charged). However, to develop the means by which boarding homes are upgraded without significantly raising the rent is not being presented in this report as the panacea. Rather, reference is made to what has come to be known as the Supportive Housing Coalition "blueprint" (footnote 10) of the full range of desirable supportive housing which was based on several assumptions, with which I concur:

- First, that mental health services, including housing, are best provided in the community;

- Second, that communities must develop the capacity to provide these services in a coordinated fashion;

- Third, changes will only occur if all levels of government are prepared to participate in finding solutions.

The term "supportive housing" is itself instructive: we cannot expect that by simply improving physical standards we will also be solving the problem. The support services structure available to chronic mentally ill people must be revised and more effectively linked to their housing. To accomplish this end, a full range of

supportive housing needs to be developed in communities throughout the City of Toronto and indeed, Metro Toronto.

The Supportive Housing Coalition identified four levels of care associated with such housing, ranging from one to four people living independently with access to on-call supervision (Level IV), to long-term high support facilities with 24 hour supervision (Level I). Although useful for detailed planning, the Levels I to IV designation is not yet widely understood and in many areas, this range of housing does not yet exist. Thus, this section of the Report is not organized using that terminology. Rather, the discussion emphasizes changes to be made to the types of housing described most often as "group homes" and "boarding homes" and "hostels." Background information derived from the current literature has already been referenced in Chapter 4 of this report.

Residential Care Facilities (Group Homes)

During the summer of 1982, the City of Toronto's Parkdale area was the scene of considerable public outcry against what were perceived as "group homes". Similar concerns were heard in other wards in the City and considerable Council debate ensued. Then and now, a confusion as to what constitutes a "group home" operates. In particular, many people seem to think that a group home is the same thing as a boarding home. Failure to distinguish between these two very different types of housing has only delayed the development of solutions.

In the City of Toronto, a group home is termed a "residential care facility" and is defined in the zoning by-law as:

(112C) "residential care facility" means a residence for the accommodation of six to ten persons, exclusive of staff, who by reason of their emotional, mental, social or physical condition or legal status require a group living arrangement for their well-being; and:

(a) such facility is supervised, or the members of the group are referred, by a hospital, court or government agency; or

(b) such facility is funded wholly or in part by any government, other than funding provided solely for capital purposes; or

(c) such facility is regulated or supervised under any general or special Act;

but does not include any use otherwise classified or defined in this by-law; (332-78)

"restrictive by-law" ..... see 18 (a)

The authors of a Canadian study recently published as a book entitled not on our street (M.J. Dear & S.M. Taylor, Pion Limited, 1982) examined the placement of ex-psychiatric patients in group homes and demonstrated that those with tolerant attitudes are more the norm than the vocal critics who have often dominated community discussion when plans to locate a group home in their neighbourhood have been announced.

At the September, 1983 public meeting which the Task Force held in Parkdale, consumers of mental health services spoke strongly in favour of group homes as an option in supportive housing. I have found that the consensus among consumers, service providers and government officials is to endorse the increased availability of this type of housing.

However, it must also be noted that "group homes" are an example of high support housing which requires extensive preliminary planning and community support as well as a considerable financial commitment (usually from the provincial government) before being put in place. Furthermore, the City of Toronto is, at the time of this report, November, 1983, the only municipality in Metro Toronto which has zoning by-laws which allow for "as-a-right" location of group homes which meet the definition of "residential care facility". Nevertheless, it is encouraging to observe the firm stand taken by Metro Toronto on this issue. Clearly, a favourable decision by the Ontario Municipal Board on this issue will be pivotal to the successful expansion of group homes in Metro Toronto.

Recommendation

Because this report is to be released at a time when zoning by-laws in Metro Toronto may soon change, it did not seem sensible to propose that group homes be substantially increased in number, even though I consider that to be a desirable and essential goal.

Instead, I have sought to recommend a course of action which will further demonstrate the commitment of the City of Toronto and of Metropolitan Toronto to the concept of group homes for discharged psychiatric patients.

RECOMMENDATION #1: THAT THE CITY OF TORONTO RE-AFFIRM ITS SUPPORT IN PRINCIPLE FOR GROUP HOMES AS A NECESSARY COMPONENT IN THE RANGE OF SUPPORTIVE HOUSING FOR DISCHARGED PSYCHIATRIC PATIENTS.

RECOMMENDATION #2: THAT METROPOLITAN TORONTO AND THE CITY OF TORONTO DEMONSTRATE THEIR COMMITMENT TO THE SOCIAL BENEFITS OF GROUP HOMES BY MAKING AVAILABLE AT A NOMINAL COST, ONE HOUSE EACH TO BE USED AS A GROUP HOME, OPERATED ON A NON-PROFIT BASIS; THE LOCATION AND OPERATION OF EACH SUCH HOUSE TO BE DETERMINED IN CONSULTATION WITH THE SUPPORTIVE HOUSING COALITION, TO BE PROVIDED FOR DISCHARGED PSYCHIATRIC PATIENTS AND TO BE IN OPERATION BY THE SUMMER OF 1984.

Boarding Homes

As with the term "group home," boarding home is not used in the existing City of Toronto by-laws. However, the term "boarding home" is generally understood to mean a rooming house where meals are provided as part of the rental charge. The Commissioner of the City of Toronto Housing Department, George C. Cook, recently co-authored a report to the Parkdale Working Group which suggested that Housing By-law 73-68 could be amended to include a definition of boarding home to the effect that a "boarding house is a rooming house where the owner or operator undertakes to provide meals to the occupants of the boarding house either on the premises or in another building operated by the owner and that the provision of the meals forms a part of the rental income of the owner or the operator." It was further suggested that such boarding houses be included as a class of rooming house in the Rooming House Licensing By-law.

In March and November of this year (1983), the Ministry of Community and Social Services announced a new program to be known as "Ecuhome", developed in conjunction with a number of churches. $1.5 million has been allocated to this project and the Anglican Church of Canada has agreed to initiate the project and invest its own funds. Although not yet operative, the boarding homes are anticipated to service "disadvantaged" residents, many of whom will not be psychiatrically disabled, but who are recipients of General Welfare Assistance administered by Metropolitan Toronto or Family Benefits Allowance administered by the Province and living in the western (Parkdale) and eastern areas of the City.

While this is a model for one type of supportive housing, there remains a good deal of scope to improve the boarding homes whose primary clientele are discharged psychiatric patients.

During the past 10 years the City of Toronto has on numerous occasions identified problems with the housing available to discharged psychiatric patients. It has been recognized for some time that a substantial number of the chronically mentally ill on low incomes have tended to concentrate in areas where boarding homes are numerous. Considerable research and discussion has centered on the idea of enacting by-laws which would govern improved physical and personal care standards in boarding homes. Repeatedly, City officials have been faced with the harsh reality that people living in many of these boarding homes literally have nowhere to go but the street if the homes are closed. As well, recent study has indicated that many of the operators of these boarding homes should not be made the scapegoats for the poor living conditions to which many discharged psychiatric patients are subjected (Report of Housing Sub-Committee of the Parkdale Working Group, June, 1983). Rather, it now seems that in many cases, boarding homes are business operations with marginal, if any, profit. The previously mentioned Report of the Housing Sub-Committee concluded that "additional standards should not be applied in any circumstance unless there is an adequate financial package attached which will permit owners of boarding houses to meet the additional requirements." The Report goes on to note that in order to meet the standards recommended, most owners will lose rented space for non rent-producing uses, for example, bedrooms will be converted to kitchens, bathrooms etc. Concern was expressed that "additional renovation costs and loss of operating revenue would ... lead to many of these properties going out of the boarding house business." Very specific proposals are made as to additional standards governing "boarding houses" to be included in the City of Toronto Housing By-law 73-68.

With regard to standards of care to be applied to boarding houses, the Housing Sub-Committee of the Parkdale Working Group concluded that "it may not be necessary to impose such standards by regulation or by-law, provided that the financial package is so designed that the money is paid directly to the operator on the condition that the property remains in use for the housing of discharged psychiatric patients and that the conditions of operation are such that they satisfy the standards imposed by the appropriate regulating agency. Failure to meet these standards should result in the removal of the financial assistance."

In the course of our deliberations on this question, the report mentioned above has been considered at some length. As well, consultations have been held with officials from the City of

Toronto, Metropolitan Toronto, the Ministry of Health, the Ministry of Community and Social Services, the Ministry of Housing, and the Secretariat for Social Development.

Recommendation

As an important initial step toward effectively improving the standards in boarding homes which cater primarily to discharged psychiatric patients without reducing unnecessarily the housing available to these residents, I have tried to devise a proposal, to be phased in over the next five years, which will not require the enactment of any additional by-laws.

RECOMMENDATION #3: THAT THE PROVINCE OF ONTARIO IN COOPERATION WITH THE CITY OF TORONTO DEVELOP AND PUT IN PLACE THE CONTRACT AFTERCARE PROJECT, (C.A.P.) TO COMPRISE THE FOLLOWING COMPONENTS:

1) AN AGREEMENT BETWEEN THE PROVINCE OF ONTARIO AND THE CITY OF TORONTO BY WHICH THE PROVINCE PROVIDES FINANCIAL RESOURCES FOR THE REPAIR AND REHABILITATION OVER THE NEXT 5 YEARS, OF 10 EXISTING BOARDING HOUSES IN THE CITY OF TORONTO, BEGINNING IN THE PARKDALE NEIGHBOURHOOD, IN EXCHANGE FOR THE CITY UNDERTAKING TO IMPLEMENT, ADMINISTER AND MONITOR THE C.A.P.

2) THE CITY WILL PROVIDE FINANCIAL RESOURCES TO THE OWNER/OPERATOR OF AN EXISTING BOARDING HOUSE FOR REHABILITATION AND REPAIR OF THE PROPERTY IN EXCHANGE FOR:

   i) COMPLIANCE WITH PHYSICAL STANDARDS SPECIFIED IN A CONTRACT (FOR FURTHER DETAILS, SEE SCHEDULE A OF THE DRAFT PROTOTYPE CONTRACT IN THIS CHAPTER).

   ii) THE PROVISION BY THE OWNER/OPERATOR OF SERVICES WHICH MEET STANDARDS SPECIFIED IN THE CONTRACT (FOR DETAILS SEE SCHEDULE B OF THE DRAFT PROTOTYPE CONTRACT IN THIS CHAPTER);

3) THE REQUIREMENT THAT THE OWNER/OPERATOR OF THE PROPERTY IN QUESTION ENTER INTO AN AGREEMENT WITH A SERVICE AGENCY WHICH IS RECOGNIZED AND APPROVED BY THE CITY AND THE PROVINCE AND IS IN RECEIPT OF FUNDING FROM THE MENTAL HEALTH COMMUNITY PROGRAM OF THE MINISTRY OF HEALTH TO ALLOW FOR THE PROVISION OF AFTERCARE PROGRAMS ON THE PREMISES IN QUESTION.

RECOMMENDATION #4: THAT THE C.A.P. BE ADMINISTERED BY AN IMPLEMENTATION COMMITTEE TO COMPRISE CITY, METRO AND PROVINCE REPRESENTATIVES WHOSE RESPONSIBILITIES WILL INCLUDE:

a) DEVELOPMENT OF A HIGH QUALITY INTERIM RESIDENTIAL FACILITY TO BE PUT IN PLACE PRIOR TO THE REPAIR OF ANY CONTRACT HOUSE TO BE AVAILABLE TO TENANTS WHO MAY BE DISPLACED DURING REPAIRS;

b) SELECTION BY PROPOSAL CALL OF THE CONTRACT HOUSES FOR THE PROJECT;

c) THE ADMINISTRATION OF THE CONTRACTS AND AGREEMENTS REFERRED TO IN RECOMMENDATION 3 AND THE IDENTIFICATION AND DIRECTION OF CITY STAFF TO CARRY OUT THE INSPECTION AND MONITORING OF THE CONTRACT HOUSES;

d) THE UNDERTAKING OF ANNUAL REVIEWS AND THE RECOMMENDATION OF CONTRACT RENEWALS TO CITY COUNCIL;

e) ENSURING THAT PRIORITY OF TENANCY IN THE UPGRADED CONTRACT HOUSES BE GIVEN TO THOSE WHO RESIDED IN THE HOUSE AT THE TIME THE CONTRACT WITH THE CITY WAS SIGNED.

The following prototype contract represents an attempt to respond to these realities and to put in place, over a reasonable period of time, one important segment of interconnected projects developed on an individual basis with appropriate boarding homes in the City of Toronto.

DRAFT PROTOTYPE CONTRACT

Introduction

The draft prototype contract provides for the physical rehabilitation of a boarding house in which ex-psychiatric patients reside and the provision of basic services to the residents. The parties to the contract are the City, and the Owner and Operator of a boarding house. Schedules 'A' and 'B' of the contract contain the physical and service standards respectively. The proposed standards draw upon the experiences and recommendations of a number of regulatory bodies and groups. Alternatives to the proposed standards can be found in Appendix C.

The implementation mechanism for the draft contract requires further development. For example, an individual named by position may be specified at a later date to undertake the inspection of the boarding house, replacing the current designation of the "City". Furthermore, an Implementation Committee will be provided with guidelines which will address such matters as the initial choice of an appropriate boarding house for contractual purposes. This choice should be partially governed by the proportion of residents who are psychiatrically disabled. During the initial phases of this pilot project the Implementation Committee will be asked to give prior consideration to houses where the owner and operator are the same person, so as to minimize the number of parties to the contract and thereby facilitate implementation. However, the contract has been drafted to allow for the possibility of the owner and operator being separate parties.

In consideration of the City's approving the Owner and or Operator as parties to the contract and thereby receiving the benefit of assistance toward physical rehabilitation of the property in question, the Owner/Operator will be expected to covenant and agree that the City shall have an option to purchase the property under terms and conditions to be developed. The purpose of such an arrangement is to ensure that, once improved, the property continues to be used as an upgraded residence for low income people, a majority of whom will be discharged psychiatric patients.

In addition, the provisions of the contract should be made to carry with the title to the property, and the term of the contract shall be for at least five years subject to an annual review by the City of Toronto for contract compliance.

The draft of this prototype contract has been submitted to the City Solicitor and we are awaiting his recommendations.

This Agreement Made this _____ day of _____ 19___.

By and Among:

THE CORPORATION OF THE CITY OF TORONTO
Hereinafter called "the City"

- and - _____,

OWNER OF A BOARDING HOUSE LOCATED AT _____
Hereinafter called "the Owner"

- and - _____,

OPERATOR OF A BOARDING HOUSE LOCATED AT _____
Hereinafter called "the Operator"

WHEREAS the City is authorized pursuant to _____ to enter into agreements with _____ respecting the physical rehabilitation of housing and the provision of services;

WHEREAS _____ is the Owner of premises located at _____, which is a licensed boarding house pursuant to the City's Rooming House By-law 502-80 as amended from time to time, hereinafter referred to as "the House";

WHEREAS _____ is the Operator of the House, in that he/she is responsible for the day to day operation of the House;

WHEREAS it is the intention of the City to assist the Owner and Operator by providing funding to physically rehabilitate the house and to provide services to the residents accommodated in the House;

WHEREAS the Owner and Operator have agreed to the physical rehabilitation of the House and the provision of services to the residents accommodated in the House;

Now THEREFORE THIS AGREEMENT THAT in consideration of the mutual covenants and agreements herein contained, and subject to the terms and conditions hereinafter set forth, the parties hereby agree as follows:

1. Financial Disclosure

The Owner and Operator covenant that a full and complete disclosure has been made relating to all financial aspects of the operation of the House, including but not limited to:

(a) all security interests attached to the House;

(b) the costs and revenues associated with the day to day operation of the House.

2. Payment of Funds by the City

2.1 The City will contribute the sum of _____ for the purpose of the physical rehabilitation of the House to meet the standards as set out in Schedule 'A' and as required pursuant to section 3 of this Agreement.

2.2 The City will contribute the sum of _____ per _____ for the purpose of maintaining the services as of set out in Schedule 'B' of this Agreement.

3. Compliance with Laws

The Owner and Operator will ensure that the House complies with:

(a) any rule, regulation, direction or order of the Local Board of Health and any direction or order of the Medical Officer of Health;

(b) every applicable by-law of the City and the Municipality of Metropolitan Toronto;

(c) every applicable statute and regulation of the provincial and federal governments.

4. Authorized Capacity

The Owner and Operator covenant that the House will be used to accommodate no more than ____ residents, or as authorized from time to time by the City in writing to the Owner and Operator of the House.

5. Financial Records and Reports

5.1 The Owner will maintain proper financial records of books of account in accordance with standard accounting procedures respecting the physical rehabilitation of the House.

5.2 The Operator will maintain proper financial records of books of account in accordance with standard accounting procedures respecting services provided to residents, and records and reports as set out in Schedule 'B'.

6. Inspections

The Owner and Operator will permit the City to enter and inspect the House and observe and evalute services and all records kept by the Owner and Operator in respect to the House at all reasonable times and at such intervals as the City deems advisable.

7. Indemnification

The Owner and Operator covenants to take full responsibility for the residents admitted to the House and covenants to save harmless and indemnify the City from all actions, claims, suits or demands of any kind whatsoever arising out of or caused by the acts or omissions of the Owner or the Operator.

8. Amendment

Schedule 'A' and 'B' which are incorporated into this agreement, may be amended from time to time by the City upon __ days written notice to the Owner and Operator.

9. Termination

This Agreement will be in force from _____ day of _____ 19__, until it is superceded or replaced by a subsequent Agreement or until:

(a) the City at any time terminates this Agreement for a breach of any of the terms of this Agreement;

(b) the City, the Owner, or the Operator terminate this Agreement upon ___ days written notice to all parties.

* Note: To be added: buy back provision.

SCHEDULE 'A'

PHYSICAL STANDARDS

Water Supply

1. The House shall be provided with a water supply system that maintains an adequate supply of potable and hot water:

   (a) which conforms in quality to the Drinking Water Objectives of the Ontario Ministry of the Environment, February, 1978 edition; and the Guidelines for Canadian Drinking Water Quality, 1978;

   (b) which can provide at least litres (gallons) of hot water per Resident per day;

   (c) of at least .562 kilogrammes pressure per square centimetre (8 pounds per square inch), when a fixture is in use;

   (d) the temperature of the water serving all bath tubs, showers and hand basins used by occupants shall not exceed 49 degrees Centigrade (120 degrees Fahrenheit) and shall be controlled by a device, inaccessible to the occupants, that regulates the temperature.

Toilet Facilities

2. (a) Toilet facilities shall be provided in at least the following ratios:

   (i) for an authorized capacity of four to seven Residents: one wash basin, one flush toilet, and one bath tub or shower;

   (ii) for an authorized capacity of a fraction of seven Residents beyond the first seven: one wash basin and one flush toilet;

(iii) for an authorized capacity of each additional seven Residents beyond the first seven: one wash basin, one flush toilet, and one bath tub or shower.

(b) Each bathtub and toilet shall have one grab bar adjacent to the facility;

(c) The bottom of each bathtub shall be furnished with non-skid material;

(d) A rack on which to hang towels and face cloths shall be provided for each resident;

(e) Bathrooms, toilet and shower rooms shall be provided with doors and shall have locks of a type that can be readily released from the outside in an emergency.

Bedrooms

3. (a) The floor area of each bedroom shall meet the following ratios:

(i) 9 square metres (96.878 square feet) for a bedroom occupied by a single Resident,

(ii) 7 square metres (75.35 square feet) for each additional Resident occupying a bedroom;

(b) A bedroom for Residents shall not be occupied for living or sleeping purposes by more than three Residents;

(c) Every bed for a Resident shall be a minimum width of 91.44 centimetres (36 inches);

(d) Every Resident shall be provided with a minimum of .68 cubic metres (24 cubic feet) of storage space in his bedroom. The storage space shall be provided with a lock and openable only by the individual Resident utilizing the facility.

Dining Room

4. (a) A dining area or areas shall be provided with the following minimum floor area:

(i) 1.858 square metres (20 square feet) of floor space for each Resident, or

(ii) 11.148 square metres, (120 square feet) whichever is greater;

(b) The dining area need not be provided in the house if the Owner or Operator provides meals in some other facility under his direct control, and the provision of such meals is included as part of the rental paid by the Resident of the boarding house.

Common Area

5. (a) A sitting room or common area shall be provided which is separate from any other area in the house and is maintained for the use of the Residents of the house;

(b) The minimum total space for the sitting room shall be:

(i) calculated at the rate of 139 square metres (15 square feet) of floor space for each Resident, or

(ii) 11.148 square metres (120 square feet) whichever is greater.

Lighting

6. The following minimum levels of illumination shall be provided:

(a) 161.45 lux (15 foot-candles) continuous lighting in all corridors, halls, at floor level;

(b) 215.28 lux (20 foot-candles) continuous lighting in all stairways, landings;

(c) (i) 107.64 lux (10 foot-candles) in all bedrooms
(ii) 376.74 lux (35 foot-candles) at bed reading position;

(d) 1076.4 lux (100 foot-candles) for drug cabinets;

(e) (i) 322.92 lux (30 foot-candles) in general kitchen
(ii) 538.2 lux (50 foot-candles) on range tops and kitchen work surfaces
(iii) 753.48 lux (70 foot-candles) on kitchen sink;

(f) 322.92 lux (30 foot-candles) in washrooms;

(g) 322.92 lux (30 foot-candles) in game rooms;

(h) 107.64 lux (10 foot-candles) plus local lighting in living room;

(i) 322.92 lux (30 foot-candles) in laundry;

(j) Lighting in other areas of the House shall comply with Illuminating Engineering Society Standards;

(k) 10.76 lux (1 foot-candle) as emergency lighting for all means of egress in Houses which are required to have a fire alarm system.

Ventilation

7. Every room shall be adequately ventilated by natural or mechanical means and shall be so designed and installed that it meets the requirements of sections 6.2 and 9.33 of the Ontario Building Code. Such ventilation shall be installed only after plans have been approved and a building permit issued, by the Chief Building Official.

8. A bedroom for one or more Residents shall:

(a) have one or more windows to the outside that,

(i) except where another means of ventilation is provided, can be opened to provide an open area equal to 5% of the floor area of the room,

(ii) is not less in total area than 10% of the floor area of the room,

(iii) is screened from May 1 to October 31,

(b) not be part of a lobby, hallway, passageway, closet, bathroom, stairway, basement, attic, kitchen, storage room, boiler room, laundry room, activity room, utility room, chapel, sitting room, administrative office, or resident examination room.

General Safety

9. The following shall be provided:

(a) handrails, of a type that will ensure the safety of Residents, installed on each side of every stairway that is wider than 111.76 cm (44"); on at least one side of each stairway that is 111.76 cm (44"), or less, in width; and on the open side of each stairway or landing, with the top of each handrail not less than 76.2 cm (30") nor more than 106.68 cm (42") above the finished floor or stair level;

(c) non-skid finishes and coverings on floors and stairways; and

(d) balustrades on the open sides of every stairway, landing, balcony, raised porch, or roof to which Residents have access; no opening in any such balustrade shall be more than 10.16 cm (4") wide.

Fire Safety

10. The House shall comply with Reg. 730-81, (The Fire Code under the Fire Marshals Act).

House Cleaning

11. (a) The House shall be maintained in a clean and sanitary condition;

(b) without limiting the generality of sub-section 11(a), maintenance includes:

(i) the sweeping and washing of the floors of all kitchens, dining rooms, bathrooms, and common passageways twice every week;

(ii) the sweeping and washing of the floors of all bedrooms once every week;

(iii) the washing of the inside and outside of all windows and window coverings including drapes and blinds once every six months.

Kitchen

12. The kitchen shall comply with R.R.O. 1980, Reg. 840, (The Food Premises Regulations under the Public Health Act).

Letter Box

13. Every Resident shall have the use of a letter box which is identified by the Resident's name and located so as to permit regular mail delivery by the employees of the Canada Post Corporation.

SCHEDULE B

SERVICE STANDARDS

Staffing

1. At least the Operator or one adult employee of the Operator shall be on duty in the House twenty-four hours a day.

Nutrition

2. (a) The Operator shall ensure that Residents are served daily with food that is of sufficient quality, quantity and nutritional value to meet the recommended daily nutritional intake as specified by the federal Department of Health and Welfare;

(b) The Operator shall post a menu once a week in the dining area or in a conspicuous place, detailing the food to be provided at each particular meal during the forthcoming week.

Linen and Towels

3. (a) Sufficient clean towels, face cloths and bed linen shall be provided for use of the Residents, and a supply of such linen shall be on hand at all times in the House;

(b) In any event, towels, face cloths and bed linen shall be changed at least once a week;

(c) All bed linen shall be changed when the occupancy of a bed changes.

Toilet Articles

4. The Operator shall provide each Resident with sufficient toilet tissue and handsoap for his or her needs.

Control of Drugs

5. The Operator shall ensure that

(a) all prescription drugs are kept in one or more locked drug cabinets;

(b) all prescription drugs are made available only to those Residents for whom they have been prescribed, as directed by the physician;

(c) the drug cabinet(s) shall contain a detailed list of contents which is kept up to date on a daily basis by the operator, and is available for inspection upon request.

Records and Reports

6. The Operator shall maintain:

(a) An up-to-date, alphabetical list of Residents showing for each Resident, his or her name, sex, age and date of admission.

(b) A separate file shall be maintained for each Resident, showing at least his or her name, sex, age; date of admission and discharge or death; name, address and telephone number of nearest relative; brief medical history; particulars of each accident suffered by the Resident.

Medical Care

7. (a) Each Resident or,

(i) his or her next of kin or legal representative, as the case may be; or

(ii) where the Resident, his or her next of kin or legal representative are unable so to do, the Operator

shall retain a physician to attend the Resident and provide emergency medical care.

(b) The Operator shall make arrangements for a physician, or substitute physician, to be on call to provide emergency services when a Resident's physician is not available.

Nursing Care

8. Wherever the physician mentioned in section 7 determines that a Resident requires emergency nursing care or "Home Care Services," the Operator shall allow such nursing care or "Home Care Services" to be given to that Resident.

Programming

9. The operator shall sign a contract with a service agency recognized and approved by the City to allow for the provision of aftercare programs on the premises specified in this Agreement. Continued cooperation on the part of the Operator in accordance with the terms of the contract between the Operator and the service agency is a condition of this Agreement.

Legal Status of Discharged Psychiatric Patients Who Reside in Boarding Homes

In response to Council's request that I report on this question, I have turned to Parkdale Community Legal Services Inc. (PCLS) for an opinion. Having served low-income clients in Parkdale for more than 10 years, PCLS seemed a valuable source of expertise on this question and I am indebted to the Director, Mary Hogan, and her staff for the following section of this report.

Introduction to the Problem

The City of Toronto has 698 licensed rooming and boarding houses and 330 unlicensed rooming and boarding houses including properties where an application for a license is being processed (Report of City of Toronto Department of Buildings & Inspections, January 11, 1983). In Ward 2, the Parkdale area, there are 95 licensed rooming houses and 49 that are known to be unlicensed. The breakdown by City wards shows that Ward 2 ranks fourth in the number of rooming houses in both categories for which statistics are available. It is of particular interest to us to note that Ward 2 ranks fourth, since our own caseload reflects a great number of problems in this area of housing. One wonders about the enormity of the problems found in those wards ranking above Ward 2. It is likely that the "South Parkdale By-law", By-law 67-78, has, since its enactment in January of 1978, had the effect of limiting the number of new licensed boarding houses in the ward as it prohibits a property's conversion to a boarding or lodging house as a legal land use in the area bounded by Queen Street, Dufferin Street, Lakeshore Boulevard and Roncesvalles Avenue.

Regardless of the actual numbers of rooming and boarding houses in Ward 2, as a form of housing they represent a relatively small proportion of the housing market, while providing shelter to a relatively large population of the Ward. The majority of that population is made up of ex-psychiatric patients. Their low income dictates the form of shelter that can be obtained while at the same time forcing the boarding home owner/operator to over-rent their facilities in order to break even or make some profit. The range of quality of shelter is almost as great as the number of boarding houses. Often the margin of profit is increased by decreasing maintenance of the property and/or providing the cheapest quality meals. Complaints by occupants regarding poor maintenance, fire hazards, over-crowding or poor meals are most often met with immediate eviction by the operator.

Competition for the better quality boarding houses is great. The outcome of this type of competition is that the residents who require the most stable housing environment eventually end up in the lowest quality boarding house.

The quality of the boarding house supply together with the great demand for cheap housing means that the slightest change creates havoc within the boarding house sector. Perhaps an example best illustrates the situation.

> One Parkdale boarding home operator runs five houses. They are not the worst nor the best quality in the range that exists. The operator leases the houses from the owner. After five months of not being paid by the operator, the owner pursues legal action against the boarding home operator and obtains a Writ of Possession. For whatever reason, the operator intends to continue operating boarding homes. To this end, three different properties are obtained by the operator for the purposes of operating boarding homes. The three facilities chosen are currently licensed as boarding homes - all are currently providing housing. Their residents receive 48 hours notice to vacate the premises. Where do the people of these three properties go? The residents of the first five houses will continue to have shelter only if they are prepared to move with the boarding home operator to the three new properties. The new facilities may be even more crowded than the old.

Status of Occupants of Rooming and Boarding Houses

In attempting to advise occupants of a rooming or boarding house as to their rights when faced with the situation described above - or any situation - the first hurdle is to establish what laws govern their occupancy. The major question is whether or not the Landlord and Tenant Act applies. If this Act does apply then a whole code of rights, obligations and procedures comes into play.

The Landlord and Tenant Act defines tenant as including "lessee, occupant, sub-tenant, undertenant, and his and their assigns and legal representatives". Residential premises are defined as "any premises used or intended for use for residential purposes" and "land intended and used as a site for a mobile home used for residential purposes, whether or not the landlord also supplies the mobile home". The Landlord and Tenant Act applies to tenancies of residential premises. it would seem to be clear that those persons living in rooming and boarding houses are indeed persons who meet both the definition of "tenant" and "residential premises" and, therefore, the Landlord and Tenant Act ought to apply to them.

However, this is not the case. The Courts have decided that for the Landlord and Tenant Act to apply, the "occupancy" must be such as meets the "traditional test" of what constitutes a landlord and tenant relationship. If such test is not met then the occupancy will be that of a licensee not a tenant,

and the Landlord and Tenant Act will not apply. Unfortunately, the law as to what this "traditional test" is, is most unclear. The criteria have ranged from that of exclusive possession and control, to the intention of the parties, and more recently to the nature and quality of the occupation. To date, no case has set out clear guidelines as to what the distinction is between a tenancy and a licence, but the cases have indicated that an occupant of a rooming and boarding house does not necessarily meet this test. Unfortunately, it is only by going to Court that the occupants know where they stand.

At best, one can say that an occupant of a rooming or boarding house may be covered by the Landlord and Tenant Act. Each situation must be examined on its own faults and merits. The Final Report of the Mayor's Action Task Force on Discharged Psychiatric Patients will contain a memorandum canvassing the caselaw in this area.

Two obvious consequences flow from this situation. Without going to Court, occupants of rooming and boarding houses can never be entirely certain of their rights and obligations, and are thus particularly vulnerable to their landlords. Secondly, for those occupants who would appear not to be covered by the Act, very few protections exist and they are in a sense "second class citizens" compared to those having the status of tenants.

Our experience with the housing problems of ex-psychiatric patients indicates that there appear to be four main problem areas: a) lack of security of tenure, b) lack of privacy, c) distraint of belongings, and d) disrepair of the premises and quality of services provided, e.g., meals.

The present Landlord and Tenant Act addresses each of these problems as follows:

(a) Security of Tenure

Since 1975 the Landlord and Tenant Act has provided some measure of "security of tenure" to tenants in Ontario. If a landlord wishes to evict a tenant then he may only do so if he has a reason and the reason is one set out in the Act. This is regardless of whether or not there is a written lease. No longer can a landlord evict a tenant because he doesn't like him or her. The reasons for eviction include, among others, non-payment of rent, damage to the premises, interference with other tenants and a desire by the landlord or his or her family to move into the premises. In order to have the tenant evicted the landlord must go to Court and obtain a Court Order to that effect.

(b) Privacy

The Landlord and Tenant Act addresses this problem in s.93 as follows:

> "93. Except in cases of emergency and except where the landlord has a right to show the premises to prospective tenants at reasonable hours after notice of termination of the tenancy has been given, the landlord shall not exercise a right to enter the rented premises unless he has first given written notice to the tenant at least twenty-four hours before the time of entry, and the time of entry shall be during daylight hours and specified in the notice except that nothing in this section shall be construed to prohibit entry with the consent of the tenant given at the time of entry."

It is an offense to breach these provisions, and a conviction carries a fine of up to $2,000.00.

(c) Distraint (Seizing and holding of a tenant's belongings for non-payment of rent)

2.86 of the Landlord and Tenant Act prohibits distraint. If a landlord is owed rent, he must sue the tenant for it, not use the self-help remedy of seizing the tenant's belongings. The Act makes it an offense to distraine with a conviction carrying a maximum fine of $2,000.00. The Act also provides a relatively quick means of applying to Court to have the goods returned if they are unlawfully distrained by the landlord.

(d) Repair

S.96 of the Landlord and Tenant Act sets out the repair obligations for both landlords and tenants, and a procedure for enforcing them. Landlords are responsible for "providing and maintaining the rented premises in good state of repair and fit for habitation during the tenancy and for complying with health and safety standards, including any housing standards required by law, and notwithstanding that any state of non-repair existed to the knowledge of the tenant before the tenancy agreement was entered into". Tenants are "responsible for the ordinary cleanliness of the rented premises and for the repair of damage caused by his wilful or negligent conduct or that of persons who are permited on the premises by him." A summary procedure in applying to the Court to enforce these obligations is provided. In addition, the Act provides a prohibition against the landlord withholding vital services, such as heat. This is enforced through the imposition of a fine.

Apart from the Landlord and Tenant Act certain other laws exist that affect both tenants and occupants of rooming and boarding houses. For example:

> Municipalities may enact by-laws which deal with such matters as standard of repair of property and, as is the case in the City of Toronto, with the licensing of rooming houses. Such by-laws give certain protections but usually the standards are minimum ones that depend on the municipality rather the individual enforcing them. The municipality's view of when action should be taken is not always the same as the individual's.
>
> The Innkeepers Act, R.S.O. 1980, C.2.7, is provincial legislation which gives an innkeeper, boarding house keeper, or lodging house keeper, "a lien on the goods of his guest, boarder or lodger for the value or price of any food or accommodation furnished to him or on his account". If part of the debt, amounting to at least one weeks board or lodging, remains unpaid for three months then the goods can be sold.

There is also a body of common law that has developed that affects tenants and licensees. Most of the law dealing with tenants has now been codified in the Landlord and Tenant Act but that dealing with licensees may have some relevance. For example:

> The common law speaks to the issues of eviction and privacy. For example, while the common law would not grant security of tenure to licensees it at least gives them the right to "reasonable notice" prior to eviction. With regard to privacy it would allow licensees (if a fee is paid for their accommodation) to sue the owner for breach of their right to exclusive possession of their premises if the owner's intrusion could be said to breach that right. Unfortunately, this is of little practical assistance. The Court processes that would be involved are slow, cumbersome and require access to legal services which in themselves can be expensive.

Conclusion

We are left then in a situation where no real protection is given to those who are deemed not to be covered by the Landlord and Tenant Act. This is particularly troublesome since these are the people who are the most vulnerable and thus particularly require protection.

However, it should not be felt that the mere inclusion of occupants of rooming and boarding houses in the Landlord and Tenant Act will solve the problems of housing for ex-psychiatric patients. Only some of them will be able to "make it" living in housing operated in the private market by private individuals with

(b) Privacy

The Landlord and Tenant Act addresses this problem in s.93 as follows:

> "93. Except in cases of emergency and except where the landlord has a right to show the premises to prospective tenants at reasonable hours after notice of termination of the tenancy has been given, the landlord shall not exercise a right to enter the rented premises unless he has first given written notice to the tenant at least twenty-four hours before the time of entry, and the time of entry shall be during daylight hours and specified in the notice except that nothing in this section shall be construed to prohibit entry with the consent of the tenant given at the time of entry."

It is an offense to breach these provisions, and a conviction carries a fine of up to $2,000.00.

(c) Distraint (Seizing and holding of a tenant's belongings for non-payment of rent)

2.86 of the Landlord and Tenant Act prohibits distraint. If a landlord is owed rent, he must sue the tenant for it, not use the self-help remedy of seizing the tenant's belongings. The Act makes it an offense to distraine with a conviction carrying a maximum fine of $2,000.00. The Act also provides a relatively quick means of applying to Court to have the goods returned if they are unlawfully distrained by the landlord.

(d) Repair

S.96 of the Landlord and Tenant Act sets out the repair obligations for both landlords and tenants, and a procedure for enforcing them. Landlords are responsible for "providing and maintaining the rented premises in good state of repair and fit for habitation during the tenancy and for complying with health and safety standards, including any housing standards required by law, and notwithstanding that any state of non-repair existed to the knowledge of the tenant before the tenancy agreement was entered into". Tenants are "responsible for the ordinary cleanliness of the rented premises and for the repair of damage caused by his wilful or negligent conduct or that of persons who are permited on the premises by him." A summary procedure in applying to the Court to enforce these obligations is provided. In addition, the Act provides a prohibition against the landlord withholding vital services, such as heat. This is enforced through the imposition of a fine.

Apart from the Landlord and Tenant Act certain other laws exist that affect both tenants and occupants of rooming and boarding houses. For example:

> Municipalities may enact by-laws which deal with such matters as standard of repair of property and, as is the case in the City of Toronto, with the licensing of rooming houses. Such by-laws give certain protections but usually the standards are minimum ones that depend on the municipality rather the individual enforcing them. The municipality's view of when action should be taken is not always the same as the individual's.
>
> The Innkeepers Act, R.S.O. 1980, C.2.7, is provincial legislation which gives an innkeeper, boarding house keeper, or lodging house keeper, "a lien on the goods of his guest, boarder or lodger for the value or price of any food or accommodation furnished to him or on his account". If part of the debt, amounting to at least one weeks board or lodging, remains unpaid for three months then the goods can be sold.

There is also a body of common law that has developed that affects tenants and licensees. Most of the law dealing with tenants has now been codified in the Landlord and Tenant Act but that dealing with licensees may have some relevance. For example:

> The common law speaks to the issues of eviction and privacy. For example, while the common law would not grant security of tenure to licensees it at least gives them the right to "reasonable notice" prior to eviction. With regard to privacy it would allow licensees (if a fee is paid for their accommodation) to sue the owner for breach of their right to exclusive possession of their premises if the owner's intrusion could be said to breach that right. Unfortunately, this is of little practical assistance. The Court processes that would be involved are slow, cumbersome and require access to legal services which in themselves can be expensive.

Conclusion

We are left then in a situation where no real protection is given to those who are deemed not to be covered by the Landlord and Tenant Act. This is particularly troublesome since these are the people who are the most vulnerable and thus particularly require protection.

However, it should not be felt that the mere inclusion of occupants of rooming and boarding houses in the Landlord and Tenant Act will solve the problems of housing for ex-psychiatric patients. Only some of them will be able to "make it" living in housing operated in the private market by private individuals with

no adjunct support services. Along with the protections that inclusion in the Landlord and Tenant Act will bring obligations - e.g., a tenant who wishes to vacate must give the landlord 28 days written notice if a weekly tenant and 60 days written notice if a monthly tenancy. In addition, tenants themselves have found that the protections offered by the present Landlord and Tenant Act are often difficult to enforce. If a landlord wishes to operate outside of the law, it requires a great commitment of time and resources on the tenant's behalf to force the landlord to obey the Act's provisions. Also, it is questionable whether the Act in its present form, is adequate to deal with such issues as the quality of services supplied, such as meals. However, even with these problems it would be a step forward to amend the Landlord and Tenant Act to make it clear that occupants of rooming and boarding houses are covered by its provisions. There is no rationale for maintaining occupants of rooming and boarding houses in a different and secondary position vis-a-vis the "traditional" tenant. The Ontario legislature recognized this when it saw fit to include such occupants in the provisions of The Residential Tenancies Act* which was to replace the present Landlord and Tenant Act. However, due to the Supreme Court of Canada's finding of unconstituionality only those provisions in The Residential Tenancies Act that deal with rent review were proclaimed and the Landlord and Tenant Act continues in force.

* The Residential Tenancies Act was intended to combine in one act all legislation dealing with landlord and tenant, and rent review matters. The current Landlord and Tenant Act dealing with residential tenants was not to be in force much longer when The Residential Tenancies Act was proclaimed.

For those ex-psychiatric patients who require support services in addition to housing, we are looking at a different type of housing and one that in our opinion is not appropriately delivered by the private sector in traditional rooming and boarding house situations. A great many more group homes with adjunct support services must be provided. Legislation such as the Landlord and Tenant Act is not appropriate to govern the relationship between the occupants and the providers of such housing, and resources must be committed by the Ontario Government to developing, in consultation with ex-psychiatric patients and community workers, additional legislation that is appropriate to such relationships.

Recommendations:

RECOMMENDATION #5: THAT THE GOVERNMENT OF ONTARIO AMEND THE LANDLORD AND TENANT ACT SO THAT IT IS CLEAR THAT ITS PROVISIONS APPLY TO OCCUPANTS OF ROOMING AND BOARDING HOUSES.

RECOMMENDATION #6: THAT THE MINISTRY OF CONSUMER AND COMMERCIAL RELATIONS UNDERTAKE TO DEVELOP PROVISIONS IN THE LANDLORD AND TENANT ACT TO DEAL WITH PROBLEMS UNIQUE TO ROOMING AND BOARDING HOUSES SUCH AS THE QUALITY OF SERVICES SUPPLIED.

RECOMMENDATION #7: THAT THE GOVERNMENT OF ONTARIO UNDERTAKE THROUGH THE ESTABLISHMENT OF AN INTERMINISTERIAL COMMITTEE, A REVIEW OF THE LEGAL STATUS OF TENANTS IN THE SUPPORTIVE HOUSING SECTOR. THIS REVIEW SHOULD BE DONE IN CONSULTATION WITH DISCHARGED PSYCHIATRIC PATIENTS, COMMUNITY WORKERS AND OTHER SERVICE PROVIDERS$ ABLE TO PROVIDE THE INTERMINISTERIAL COMMITTEE WITH ESSENTIAL PRACTICAL KNOWLEDGE NOT OTHERWISE AVAILABLE, WITH A VIEW TO ENSURING THAT THESE TENANTS ARE AFFORDED APPROPRIATE PROTECTION COMMENSURATE WITH THE UNIQUE AGENCY/RESIDENT RELATIONSHIP IN SUPPORTIVE HOUSING.

6. CRISIS INTERVENTION SERVICES

In the course of the Task Force examination of coordinated aftercare for the chronic psychiatrically disabled, a serious gap in services was initially brought to our attention by a representative from Nellie's Hostel for Women. In a report released in May of 1982 entitled The Role of Nellie's in Providing Psychiatric Aftercare, the rapid increase in the number of women coming to the hostel with a psychiatric history was documented. From the perspective of the people operating the hostels, a serious problem arises when a resident goes into psychiatric crisis. Hostel staff are not trained to cope, yet support from the community is often unavailable. This is especially true for hostels where children are accommodated. As a last resort, police are called, but police have limited powers under the Mental Health Act of Ontario. According to Constable Michael Fredrico of the Metropolitan Toronto Police, an officer must witness the individual acting in a bizarre fashion and must have knowledge that the individual is mentally ill before the officer has the authority to make an arrest under Section 11 of the Act. Constable Fredrico reported that the number of arrests under all relevant sections of the Act has increased by 54% over the past 4 years.[1]

Both police and the Nellie's report identify considerable difficulty in arranging admission to the psychiatric wards of general hospitals for those who (in their view) require medical attention. These concerns are echoed by members of the Supportive Housing Coalition, which is in the process of examining the problem of finding appropriate care for residents who are going through crisis in the houses SHC operates. In the 1981 SHC "Blueprint", a mobile crisis team and short term acute care residence was recommended (p. 37). As previously mentioned, the Metro Toronto District Health Council is researching the coordination of mental health services (including crisis intervention services) and expects to release a report in May.

Preliminary results from interviews with the psychiatry departments at the acute care general hospitals indicates that planning mental health care often takes place in isolation. A recent illustration of the size of the problem may be seen in the failed attempt of the teaching hospitals to set up a common bed registry. Apparently this failure was due to a lack of trust and the custom of independent hospital operation. The problem of emergency care for patients in psychiatric crisis was often viewed in terms of a bed problem according to the DHC's chief researcher. Another major issue was that psychiatric residents were having to spend lengthy periods of time phoning around for beds in order to accommodate patients in crisis. If a presenting psychiatric

emergency case had "recently" been cared for by a psychiatric hospital, frequently the person was sent back to the psychiatric hospital. Unfortunately this procedure does not guarantee admission. This problem has been perceived by a number of service providers, police and consumer groups with whom we have consulted. But there is also concern about the reliance on general hospitals or psychiatric hospitals as the primary resource for discharged psychiatric patients in crisis. On page 64 of the 1981 report by the Community Resources Consultants of Toronto and the Social and Community Psychiatry Section of the Clarke Institute of Psychiatry, entitled Psychiatric Aftercare in Metropolitan Toronto, this concern was expressed as follows:

> If aftercare services, wherever they are located, continue to be seen as hospital services, then the illness model will be reinforced and discharged patients will continue to see themselves as sick and to function in accordance with the rules of illness behaviour. In order to shift this pattern, aftercare services must espouse a rehabilitative educational philosophy and they must be seen as separate and distinct from acute care, medical-model, hospital services.

Without question there are medical psychiatric emergencies when hospitalization may be the most appropriate form of treatment for the patient. It is also clear that a great deal of work remains to be done with regard to integrating the services provided by the psychiatric wards of the general hospitals into a coordinated system. But we are of the opinion that a free-standing short-stay residence for people in psychiatric crisis, without hospitalization, would serve to address many of the pressing service needs. This free-standing clinic would complement the role of the general hospitals, and would not be effective without a strong link to a general hospital. It is neither our intention to remove the responsibility for care from the general hospitals nor is it our intention to simply add on another service: but for the chronic psychiatrically disabled living in the community and for those who provide services to them, this crisis centre can fill a genuine gap in Metro's supportive structure. The establishment of such a free-standing crisis residence in a large metropolitan centre such as ours constitutes a challenge in planning and in allocation of financial resources. We have received documentation on models developed in New York City and in Vancouver. We visited the four-year-old crisis intervention team in Mississauga Hospital to examine directly an autonomous crisis model within a general hospital. These models will be described before the proposal is outlined.

1. Mobile Unit, Lincoln Community Health Center

In the southeast Bronx, New York City, the Lincoln Community Mental Health Center was established in 1963 as a result of

the Mental Health Act and the creation of the Office of Economic Opportunity - both federal initiatives. The center was responsible for the comprehensive delivery of all mental health services for a population of close to 200,000 people of which 60 percent were Puerto Rican, 30 percent were black, and 10 percent white. The Center employed 203 people and was organized as follows:

in-patient department of 80 beds located at Bronx State Hospital;

out-patient department consisting of 3 decentralized clinics;

partial hospitalization service consisting of a day hospital for 25 patients and a night emergency unit with 5 beds for short-term crisis intervention;

emergency services which functioned 24 hours a day, 7 days a week, with full medical and surgical backup from Lincoln Hospital and a Mobile Crisis Intervention and Suicidal Prevention Unit that provided backup on-the-spot consultations at the scene of the emergency;

consultation and education services available to agencies and community groups for training of skills and educational support to specific programs;

rehabilitation services offered for patients on their way back into the community;

addiction services which had a capacity for 150 patients as well as several community based drug-free treatment programs;

liaison services which provided precare and aftercare services for the in-patient and the partial hospitalization departments;

training department which offered on-the-job training for non-professionals so as to promote career development for the less skilled staff members as well providing training opportunities for students in various helping professions.

Given the gaps in service identified by service providers in Toronto, we have specifically considered the Mobile Unit devised in the Bronx. For the purposes of the Unit, crisis was defined as "a situation that arises after ancillary services and family strengths have been depleted and the resultant is a change in the equilibrium of an individual or a family." The entire outlook of the program was oriented

toward (a) the family as a unit with all attempts at assistance encompassing the entire family group; (b) the staff as part of a comprehensive setting and thus able to utilize the full facilities of the center; and (c) in-patient hospitalization always as a last alternative to be avoided except in extreme cases.

During the course of its operation, the Unit dealt with all psychiatric emergencies encountered in that urban area. The success of the service was attributed to its ability to get involved quickly, to make appropriate consultations based on clinical and community knowledge, and to deal with people on a grass-roots level. The effectiveness of non-professionals was emphasized as was the suitability of the service as an excellent training ground for community and social psychiatry.

In 1975 and 1976, the City of New York experienced serious financial insolvency and there were severe budget cuts in the City's health care delivery system. The Center was notified in June of 1975 that its annual budget of almost $4 million was to be reduced by $750,000 within one month. In June of 1976 the Center's annual budget was reduced to $.6 million. These actions forced the reduction and elimination of services geared toward primary prevention (consultation services to community agencies) and tended to strengthen the hospital-based programs.

In an analysis published in the American Journal of Psychiatry 136:1, January 1979, Dr. Pedro Ruiz was of the opinion that it would have been possible to take a more constructive approach to cost-savings, without eliminating the entire model. His proposals included:

- the enactment of appropriate legislation at all levels of government to unify services so that fewer providers delivered more services;

- centralization of administration;

- use of consortium models for service delivery;

- comprehensive planning considering long and short range goals to avoid introducing measures that would only create financial problems later;

- collaboration between local and state government to define goals of mental health care delivery to ensure continuity of care and special support for prevention;

- development of effective community representation;

- catchment areas defined according to the natural locus of needs for services, not according to political or geographical boundaries;

- independent third parties with authority to monitor and evaluate ongoing programs.

2. Venture Emergency Residence, Greater Vancouver Mental Health Service

As with the Bronx model, the Greater Vancouver Mental Health Service (GVMHS) provides an extensive system of community care; Venture Emergency Services comprise one part. In a March, 1982 publication of the Mental Health Division of Health and Welfare Canada (one of a series of descriptive publications on good Canadian models of mental health service), the GVMHS was chosen "as a uniquely outstanding and successful example of an urban community mental health service designed specifically to care for the most difficult of client groups - the long-term psychiatric patient."

The Service's catchment area includes the City of Vancouver and the Township of Richmond, two municipalities with a total population of approximately 500,000. Funding for the GVMHS now comes directly from the Ministry of Health. Initial funding came through an agency supported by the provincial Ministry of Health but with the advantage that new projects could be financed without the usual delays caused by lengthy reviews and without the requirement that monies not spent during the budget year had to revert to Treasury. Only when the GVMHS changed from an experimental project to an established agency was the funding provided in an orthodox government manner.

Venture Emergency Residence

The GVMHS operates Venture as a ten-bed short-stay emergency residence to house patients who require temporary removal from a stress situation, but for whom hospitalization would be unnecessary or undesirable. Ninety % of the admissions to Venture are referrals from the GVMHS community care teams. Besides supervising residents, Venture staff also run an individualized day care program for a limited number of individuals and a drop-in program for individuals who have refused ongoing psychiatric help. Venture's staff also operate an after hours drop-in service, which serves approximately ten people per evening. Food, coffee, and companionship are offered. Venture has also started a community adjustment program by setting aside two beds to accommodate male patients

newly discharged from hospital whose ability to adapt to community living is in doubt.

From the outset, the GVMHS considered itself to be a 24-hour service; however, the costs of having 8 staff on call proved prohibitive. Initially, the after-hours coverage was the responsibility of the community care teams in the different catchment areas. Now, all after-hours calls are routed to Venture and if necessary, other staff, including an on-call psychiatrist, are brought in to attend psychiatric emergencies on the spot.

Clear negotiated agreements with other service providers is central to GVMHS's operating strategy. GVMHS has developed a written agreement with the Vancouver Police Department regarding psychiatric emergencies. If the police encounter a psychiatric emergency, they call Venture and a staff member will go to the scene to offer assistance in a car leased by Venture. In return, if Venture receives a call where there is a threat of violence, they contact police who are required to be on stand-by. If the situation turns violent, the police take over. This mobile response capability, the leased car and staff member, are part of Venture's "after hours services". The keystone of the after hours operation is the Venture emergency telephone number, which is widely known in the community. The majority of requests for help are handled on the phone by a staff member on duty at Venture. Many of these calls are from chronic psychiatric patients who may have been in the short stay facility at Venture. Calls regarding medication problems are quite common. Due to Venture's close proximity and working relationship with Vancouver General Hospital, on occasion police will take a psychiatric emergency from the Vancouver General Emergency Department to Venture. The Venture Mobile Car will go out in certain cases after hours. Because of budget cutbacks, there is now only one staff member available to go out in the car so the mobile response capability is more limited than at its inception. The Venture staff member is expected to respond if it is certain that there will be someone to assist them in the crisis situation. This crisis locale may be a boarding house, a hostel, or a long-term care facility. The staff member judges whether or not they can safely respond, but if it sounds like a very serious or dangerous situation they call police. In the wake of the cutbacks, Venture has a written agreement with the Vancouver Crisis Centre, which is a volunteer service operating a hotline for suicide and crisis intervention. The Crisis Centre has a "flying squad" composed of volunteers who will go out at night and attend to cases. In certain situations, Venture staff will call on the "flying squad" to respond to an emergency.

The Venture staffing arrangements are as follows: a director (currently a senior nurse), a secretary, a cook, and 12 full time staff who work shifts i.e., 4 days on and 2 days off. Full time employees are complemented by a number of on-call clinicians. So in effect, Venture has 13 clinical establishment positions. (letter dated July 29, 1983 from GVMHS).

Venture has close contact with other agencies such as the Metro Ambulance Service and with Vancouver General Hospital (which has the regional emergency ward). The average length of stay was 7 days per inpatient and 6.2 days per crisis patient. The day patient and drop-in program provided service to a total of 2,287 "drop-ins" during the first ten months of 1983. Director of Support Services Helga Hicks reports that the 1982-83 budget was $564,570. This includes the Emergency After Hours Services (accounting for one third of salaries) but does not include fees for psychiatrists on call to Venture. The per diem is $154.60. (see Appendix B). It is important to recognize that Venture is very selective about their admissions criteria. They draw a strong distinction between an emergency faced by a patient with psychiatric problems (e.g., food vouchers, medication problems) and a genuine psychiatric emergency. Venture will admit only the psychiatric emergency. Over 90% of the crisis cases admitted to Venture are referrals through the community care teams. The remaining 10%, a small percentage, are admitted through the after hours route. The Director of Support Services admits that Venture has been accused of being too particular when deciding who is mentally ill and who is not. Venture will not deal with either the mildly disturbed individual, or "the very nasty and non-compliant". In this way, Venture is clear about its goals, recognizing that it cannot do everything for everyone. It is also a strong policy that only adults can be admitted to Venture. Many of the emergency cases that Venture is unable or unwilling to handle are referred to two downtown hostels.

3. Crisis Intervention Team, Mississauga Hospital

Mississauga Hospital, on the outskirts of Toronto, serves a suburban population of approximately 320,000 people. Four years ago, the Department of Social Work at the Mississauga Hospital recommended that a Crisis Team be established to support the Emergency Department. The social workers had determined that the needs of some of the people coming into the Emergency Department in states of what they called "psychosocial distress", were not being met. There had been some suicides following emergency assessment. Lakeshore Psychiatric Hospital had closed down the year before. The

proposal, submitted to the Ministry of Health, Program Development Branch, initially asked for funds so that a social worker could provide consultation to doctors and nurses in the Emergency Department. Upon receipt of $60,000, they had enough money to hire three new people. The coordinator spent the first three months negotiating with the various systems, both in the Emergency Department and in the community. The negotiations focused on setting up communications, and determining mutual expectations. The patients that the service was designed for were to be by referral from Emergency only, and there was to be "no dumping" of hard to handle or unwanted community agency cases. The program was to be an adult assessment referral unit, and no children were to be accepted. From the beginning, no chronic psychiatric cases that posed severe behavioural or management problems were to be, as a rule, accepted. The advantages offered by the Crisis Intervention Team were as follows:

- greater intensity of care;
- more time available to spend with clients than would be possible for medical personnel; in some cases this meant half a day;
- emphasis on coordinating efforts to handle the crisis with family and friends of the patient playing a central role;
- emphasis on referral and follow-up.

The initial client target for the three staff members was 80 per month. After the third or fourth month, this target was achieved. The clinic is currently handling 120 - 130 cases per month. They operate with three full-time social workers on staff, and three part-time staff. The operating budget is now $150,000 per year, and the Team is on permanent funding. Clinic hours are 9:00 a.m. to 10:00 p.m. Monday through Friday, and 2:00 p.m. to 10:00 p.m. on weekends. This does not include the fact that often the staff do not leave until 12:00 midnight if there is a late-breaking crisis. The Crisis Intervention Team operates autonomously from the Psychiatry Department, but has a strong liaison with the staff in the Emergency Room and with some of the community agencies. Staff turnover has been quite low over the four years of the Crisis Team's operation. Great emphasis is placed on internal morale, and the Team self-consciously operates on a democratic basis.

Of the 130 handled per month, an estimated 30% are psychiatric emergencies. This percentage does not include "people with emotional problems due to loss; for example, depressions based on grieving". Under its mandate, the Team does not go out and

seek cases in the community, rather they take referrals from the Emergency Department. Due to the lack of facilities for ex-psychiatric patients in the community of Mississauga, there are few chronic psychiatric crises arriving at the Emergency Department. According to the Coordinator of the Crisis Intervention Team, if a chronic psychiatric patient comes into the clinic with a housing problem, generally he or she is referred to downtown Toronto.

With the psychiatric emergencies received (i.e. those not judged medically serious enough for a psychiatrist's attention), the goal of the Crisis Intervention Team is to keep the patient outside of hospital. Apparently, this goal has met with the approval of the psychiatric staff, as the psychiatrists are dealing with a more seriously ill population. The advantage of a crisis team composed of social workers is that for particular psychiatric emergencies, the patient may not need individual therapy, but rather, may need someone who is able and willing to be active and involved in solving the problem. The emphasis for the Team is on the use of friends and family in helping the patient. As the Coordinator put it succinctly, "we try to help them survive". It is interesting to note that if a patient is admitted to the psychiatric ward from the Emergency Department, the patient is referred to an in-patient psychiatric social worker. The Crisis Intervention Team does not have a role in following up these cases. Apparently, this is because they do not have the resources. It is also interesting to note that the psychiatric crises that do require the attention of the Intervention Team occur around the clock, but 30% of the cases occur before one o'clock in the afternoon, another 30% before six in the evening, and 40% thereafter. The Coordinator repeatedly stressed that the success achieved by the Mississauga Hospital Crisis Intervention Team is to a large extent dependent upon the quality of staff attracted to the job (i.e., dedication, willingness to work lengthy hours without overtime), and to the degree of coordination between the team and staff in both the Emergency Department and the outside community agencies.

The Coordinator of the Crisis Intervention Team for the Mississauga Hospital has travelled widely throughout Canada and the United States visiting a variety of crisis intervention centres. His view is that there is a chronic psychiatric population that needs very structured community settings, but these have not been provided. Because of the lack of resources, no one wants to deal with this population, so they are simply sloughed off. In general, he agreed that a free-standing clinic would be a far more appropriate way of meeting the problems of the chronic "hard-core" ex-psychiatric population. In view of the Mississauga Crisis Intervention Team's emphasis on staff quality and morale, it is

understandable that he would have difficulty with the idea of one social worker or crisis person being attached to an emergency room in a general hospital. He felt that this individual might burn out quickly without the support of colleagues. "This is demanding, emotionally intensive and not necessarily rewarding work". He expressed a further concern on the question of seconding staff for a free-standing clinic. His concern was that such people might come entrenched in a particular helping modality, and thus place a greater emphasis on the passive, reflective medical approach as opposed to the action-oriented interventionist approach. In an acute psychiatric crisis, of course medical personnel are required; but people, particularly the chronic population in crisis, often do not need a reflective or medical approach. They require someone who can be innovative in trying to assist them (in other words, someone who can get involved).

Conclusions

While more detailed research is certainly required, in the course of the Task Force examination of crisis intervention we have drawn the following conclusions:

1. Currently there exists a serious gap in supportive services for the chronic psychiatric population. Estimated at 1,800 Metro Toronto residents - these are the people who are no longer in hospital - but not yet adequately supported in the community. This gap in services has been identified repeatedly by those on the front lines: hostel staff, police, consumer groups, providers of housing and aftercare programs.

2. On the whole, the general hospitals' psychiatric departments have not assumed the responsibility for the chronic population envisioned in the deinstitutionalization program.

3. Serious reservations exist about the appropriateness of taking a medical approach to a community care model.

4. At least in the short-term - five to ten years - efforts to coordinate aftercare services will continue. This is particularly true in the area of housing.

5. At the same time, history has shown that the chronic psychiatric population will experience crisis periods. The chronically psychiatrically disabled have a need for and a right to support during these crises.

6. In order to achieve the hoped for transition to a more coordinated system, all providers of psychiatric aftercare will need support for their efforts, particularly those providers of housing services.

7. In addition, the public has a right to expect that mental health services in the community will be coordinated and that support in crises will be available.

Recommendations

In light of the above, we strongly recommend that a free-standing community crisis centre be established in Metro Toronto. This model is proposed only as a necessary complement to other components of a coordinated psychiatric aftercare system.

RECOMMENDATION #8: THAT A TORONTO COMMUNITY CRISIS CENTRE BE SET UP ALONG THE FOLLOWING LINES:

1. In general, length of stay to be less than 7 days. The objective is to help a person in psychiatric crisis to become sufficiently stabilized so that he or she can return to the community without inappropriate hospitalization. Methods will include short-term supportive counselling; effective referral links; concrete assistance with immediate crisis related problems; access to self-help support or counselling where appropriate; medication where appropriate. Methods will not include forced medication. The expectation is of a speedy return to the community.

2. The target clients are chronically psychiatrically disabled persons in crisis who lack supportive resources. The centre is not designed for involuntary clients. Initially it is anticipated that within these parameters admission criteria must be flexible. The centre should strive to avoid a too restrictive application of "chronically psychiatrically disabled". At the same time, the target is psychiatric crises of a chronic nature - those whose needs are demonstrably neglected - and the original mandate should not be diluted.

3. A free-standing centre located in a residential house in downtown Toronto.

4. Fifteen beds be available in a comfortable, non-institutional environment.

5. The hours of operation be 7 days per week 24 hours per day, holidays and weekends included.

6. Funding from Ministry of Health, Community Health Programs Branch. Estimated start-up costs $644,800. Annual cost $500,000. See Appendix C.

7. Crisis centre to be operated and managed by a community board responsible to the City of Toronto and the Ministry of Health. Predecessor to this board should be a group considering the

detailed implementation. This group should include local residents, service consumers, Supportive Housing Coalition Sub-committee on Crisis Care.

8. Mandate be reviewed after three years of operation. Evaluation to be based on the number of clients served, endorsement from psychiatric aftercare providers and consumers, staff assessment, board.

9. Quality of staff critical to effective operation. Centre staff to include medically trained and community trained mental health care workers. Following Vancouver Venture House model:

    1 coordinator/director.
    9 clinical staff (registered nurses, registered psychiatric nurses, public health nurses, or psychiatric social workers.)
    3 community mental health care workers.
    1 cook.
    1 secretary.
    plus relief staff. 3 staff on duty at all times.

10. Psychiatrists and medical staff be seconded on a rotating basis from the general hospitals, especially the teaching hospitals. One psychiatrist on call for medical emergencies, possible admission to hospital, and prescription of medication.

11. Strong links be forged with the general hospitals' emergency departments and psychiatric wards as well as case managers. Centre is intended to be free-standing, an alternative step but not isolated from hospital or community.

12. Effective referral links be established and maintained to and from community services. A central objective in early stages of the program to be liaison with potential users of the service - hostels, consumer groups, police, boarding home operators and families.

13. Part of preliminary process to include extensive training for staff with a view to gaining awareness of services available as detailed in District Health Council Inventory of Mental Health Services in Metro. Similarly, a vital early task is for crisis centre staff to educate service providers and community resource groups on the centre's role.

14. From the inception of the program a leased car and at least one staff member be available for mobile community problem intervention.

15. In the second year of operation, a distress line be added to the service. Initially, the 911 emergency number for referrals should be encouraged. The "hotline" seems particularly valuable in view of the Vancouver experience where many problems that can turn into emergencies - for example, uncertainty about medication - can be forestalled on the phone. Liaison with general distress lines now in operation should first be undertaken.

This proposal is an ambitious and costly undertaking. Without doubt there are many issues that must be resolved before such a community crisis centre can be achieved. At one extreme, the "anti-psychiatry" spokespeople may disapprove of the medical aspects of the model; at the other extreme those who believe the psychiatrist is God will not be satisfied. But it is my view that a community-based crisis centre with a medical component can provide a complement to other services and meet an urgent need that is not being met now.

Implementation of the community crisis centre will require strong backing - political endorsement by City Council and the Cabinet, and the time and support of the many groups involved in the field of mental health care. I recommend that first steps be taken as soon as practical.

RECOMMENDATION #9: THAT THE GENERAL HOSPITALS IN THE CITY OF TORONTO SERIOUSLY CONSIDER THE ESTABLISHMENT OF CRISIS INTERVENTION TEAMS BASED ON THE MODEL WHICH HAS BEEN DEVELOPED AT THE MISSISSAUGA HOSPITAL.

RECOMMENDATION #10: THAT THE MINISTRY OF HEALTH SERIOUSLY CONSIDER INCREASING FUNDING FOR EXTENSION OF HOURS AT AFTERCARE SERVICES USED BY DISCHARGED PSYCHIATRIC PATIENTS IN CRISIS, SUCH AS THE SATELLITE CLINICS OF THE QUEEN STREET MENTAL HEALTH CENTRE, THE PARKDALE ACTIVITY AND RECREATION CENTRE AND SOME PROGRAMS RUN BY SELF-HELP GROUPS.

7. COORDINATION OF AFTERCARE SERVICES

The term "aftercare services" encompasses a rather intimidating array of organizations with different structures and different definitions and different methodology. Earlier this year (1983) the Thames Valley District Health Council completed a comprehensive study of adult mental health services delivery for that area of Ontario. While many of their conclusions may not be appropriate in the context of Toronto, the descriptions developed by the Task Force of common denominators of aftercare support has been most useful. This chapter has been organized with reference to those common denominators, taken from Appendix III of the report entitled, "Status of Adult Mental Health Services Delivery, Thames Valley District Health Council, 1982/1983."

1. Standard Discharge Planning Process to begin in the hospital or psychiatric facility prior to actual discharge.

2. Aftercare/Caseworker to be assigned to each patient prior to discharge, to remain available to the client until able to manage on his/her own or until only periodic maintenance check-ups are required within the home environment.

3. Graduated Housing, another term for a range of supportive housing, should be immediately available. To quote the Thames Valley Report at page 3: "as seen by data and review, clients worry over basic shelter, food and income needs and this leads to depression and re-admission to hospital."

4. Crisis Team Intervention available on a 24-hour (7 days a week) should be provided for clients "acting out" and be on call to clients, hospitals, landlords and families of the chronically disabled people who live at home.

5. Case Management Committees available to individual case workers to ensure frequent ongoing assessment aimed at rehabilitation, consistency of follow-up, providing solutions for hard-to-serve people who may still tend to fall between the gaps in service.

6. Coordinating Committee for Hospitals, Community Agencies and Aftercare Workers with the mandate to ensure community cooperation and coordination to meet the needs of discharged patients in an effective way.

7. Vocation Training, Including "Sheltered Workshops" to make appropriate workshop programs available to serve members of the chronic psychiatric population as well as the developmentally handicapped (mentally retarded).

8. Re-assessment of Staffing Needs in order to ensure a holistic approach to treatment and programming, not just from a medical model sense. In preparation for this, hospitals and community agencies will need to assess their roles in aftercare and it will mean coordination with a view to an extension of role mandates using available staff wherever possible.

9. Communication and Interaction Amont Hospitals, Psychiatrists and Community General Practitioners to be developed for each individual patient case to ensure that those working outside the hospital setting are well informed and that confidentiality is ensured.

10. Central Placement Service to be used to properly place clients within the supportive housing available and in accordance with the discharge plan.

11. Public Awareness Program to be developed by the coordinating committee mentioned in point 6, with the cooperation of organizations in the community such as advocacy groups working in cooperation with service clubs, to hold educational seminars in places such as schools, shopping malls and during Mental Health Week.

This section of the report has not been organized strictly along the lines of the 11 points developed above because the situation in Toronto is by no means identical to the Thames Valley Region. However, with these 11 points as the "big picture" let us now turn to an examination of the situation in Toronto.

Reference has already been made to the extensive report prepared for the Parkdale Working Group by the Clarke Institute of Psychiatry Consulting Group entitled "Systems Coordination for Psychiatric Services in Toronto," June, 1983, which suggests a pilot project for coordination of aftercare services in the western of the City of Toronto, including the Parkdale area. For further background information see the Psychiatric Aftercare Service section of chapter 4. This report deals with the 11 points listed above, but in the context of the City of Toronto and Metropolitan Toronto. Considerable discussion has ensued since the introduction of the report this past summer and the Parkdale Working Group has recently decided to accept the general principles of the Report, and to incorporate them in a coordination pilot project related to case management for chronically psychiatrically disabled people in the Parkdale area. This project will be designed to improve local service delivery in the Parkdale area but will also relate to the long-term goal of service coordination in Metropolitan Toronto. The project is to be further developed by the Ministry of Health in consultation with the Parkdale Working Group for implementation in this calendar year (1983).

Parkdale Mental Health Coordination Service (PMHCS)

This is the title which has been given to the pilot project mentioned above. From the information recently made available to us, we are impressed with the proposal to provide a single channel through which chronic discharged psychiatric patients who have access to the services of a case manager can be placed into programs most appropriate to their individual needs. Such a single channel will prove valuable in the following ways:

- to promote equitable and optimal placement of clients;
- to provide a vehicle for monitoring and negotiating the placement of clients into appropriate programs;
- to provide a consistent data base regarding gaps and duplications of services to alert groups developing programs.

Having reviewed the proposal for the Parkdale Mental Health Coordination Service I am favourably impressed with several aspects of the proposal and pleased by the decision to move quickly in developing the service.

Recommendation

Having had the benefit of the multidisciplinary expertise represented on my Advisory Committee, I am further convinced that successful coordination of aftercare services in the City and Metropolitan Toronto is a necessary but complex process which has to be developed in stages. To be successful, this coordination service must not only be supported and respected by health and social services agencies but it must be recognized in the community and by clients as a necessary means of achieving effective and efficient use of resources. For this reason I recommend as follows:

RECOMMENDATION #11: THAT THE PMHCS BE ENDORSED IN PRINCIPLE BY THE CITY OF TORONTO, PROVIDED THAT THE INITIAL STAGE OF THE SERVICE MUST BE THAT OF EXTENSIVE CONSULTATION WITH THE AGENCIES, INCLUDING HOSPITALS AND THE QUEEN STREET MENTAL HEALTH CENTRE, WITH A PARTICULAR EMPHASIS BEING PLACED ON CONSULTING WITH CONSUMERS OF MENTAL HEALTH SERVICES IN THE PARKDALE AREA.

8. ATTITUDES: BARRIERS TO COMMUNITY MENTAL HEALTH

One of the major barriers to community support for psychiatrically disabled is attitude - everyone's attitude toward an issue which arouses archaic dread and fears of a person who is "not normal". As we discussed in the History Section, perspectives toward mental health and illness, have changed - but still these attitudes exist. Dear and Taylor in the introduction to their valuable study on public attitudes toward group homes for the psychiatrically disabled in Toronto point out that:

> "Public attitudes to the mentally ill and to the facilities which serve them are of fundamental importance for the success of deinstitutionalized care in two ways. First, from the perspective of the ex-psychiatric patients, the attitudes of residents in neighbourhoods where facilities are located are of great importance in determining their social integration in the community. The potential therapeutic value of being part of a "normal" environment can be seriously weakened or entirely lost if local residents demonstrate rejecting attitudes. ... The second major reason why public attitudes toward the mentally ill are important relates to planning. Deinstitutionalization presents government and social service agencies with a very difficult task, mainly to provide a network of facilities adequate to meet the needs of patients discharged from hospital and of those who would previously have been sent to hospital-based institutions. In many instances, the decrease in the number of institutionalized patients and the consequent increase in community care clients has been so rapid that the demand for community facilities has inevitably outreached the supply. The gap has been partially met, but there remains the need to establish many more purposely created facilities in the community."

On this same question, then Health Minister, Larry Grossman commented in an April 1983 speech: "A recent Ministry study shows that the more that Ontarians know about the needs, the benefits, and the successes of community based programs for people challenged with mental health difficulties, the more they support that."

The news media play a significant role in spreading this knowledge and shaping these public attitudes. In general the media in Toronto have been very responsible. Often the media have served as voices for the voiceless - highlighting abuses and ensuring that the plight of the mentally disabled remains on the political and social agenda. We commend the media for their actions. At the same time, a socially responsible media should continue to educate its members about the attempted solutions to the obvious problems in the mental health field. While the failings of the

system, invisible abuses, must be reported, the dramatic case of abuse should not overwhelm attention to the positive (often slow and incremental) process of change.

We also applaud the joint efforts of the Ontario Ministry of Health and the Candian Mental Health Association (Ontario Division) for their $1.5 million communications campaign for public awareness. More needs to be done in this regard, but it is heartening to see public education addressed in a sophisticated and direct manner.

Educational seminars - such as the workshops on group homes sponsored by the City of Toronto and the Secretariat for Social Development - are also a step in the right direction. In addition, many volunteer organizations have contributed tirelessly to the goal of public education. We thank all these groups for their efforts and trust that they will continue. The ex-psychiatric advocates clearly have an instrumental role to play in raising public awareness. All these attempts to reach the public are ongoing and important, as are the many research undertakings which have been mentioned throughout this report.

Still, the question of "not on our street" remains. The Task Force will make no formal recommendations in the area of public education other than to applaud the diverse efforts under-way and to sincerely urge concerned citizens and the politicians who are elected to serve them, to recognize the importance of this issue, and to act out of moral conscience. There are sincere people who believe in community mental health care, yet continue to insist "not on our street." We view this attitude as misguided and firmly maintain that these fears can only be allayed by the continued successful integration into the community of caring environments for the psychiatrically disabled. It is critical in this regard that all areas of the community share this responsibility. Actions speak louder than the words of a few - and we urge concerned citizens and officials to keep this firmly in mind when weathering the inevitable storms.

I would like now to return to a point first made in my introduction to this report. If we, as citizens of Toronto, are to be proud of our City, we must face an undeniable reality. The greatness of our City is not judged only on its architectural monuments, clean streets or efficient subways. The true measure of a civilization rests on how it treats its vulnerable members. It is on this, we too are being judged. I strongly urge my fellow citizens to do what is right -- not what seems, in the short run -- politically expedient.

APPENDIX A: A COMPARISON OF PHYSICAL AND PERSONAL CARE STANDARDS IN REGULATING BOARDING HOMES

INTRODUCTION

Because of the wide variance of standards among regulatory bodies in Ontario, the following sources have been surveyed to develop an overview of alternative physical and personal care standards that could be applied to boarding homes in which ex-psychiatric patients reside:

(a) The City of Toronto's Housing By-law, No. 73-68, (hereinafter the "Housing By-law").

(b) Other existing legislation such as the City of Toronto's Zoning By-law No. 20623 (hereinafter the "Zoning By-law") and the Ontario Building Code.

(c) The City of Hamilton's Second Level Lodging House License By-law, consolidation of By-laws 80-259 and 81-93 (hereinafter the "Hamilton By-law").

(d) Guidelines for Resthomes, Lodging Houses, Group Homes, originally issued by the Ministry of Health in February of 1980, and re-issued in December of 1980 (hereinafter the "Ministry Guidelines").

(e) Report of the Housing Sub-Committee of the Parkdale Working Group on Housing Proposals for Discharged Psychiatric Patients, June 24, 1983 (hereinafter the "Parkdale Working Group Report").

I PHYSICAL STANDARDS

1. Water Supply

(a) Housing By-law s.25(9):

> (9) An adequate supply of potable water shall be available at all times in all parts of every dwelling, subject to the exceptions provided in section 30.

(b) Hamilton By-law s.6(a):

Every house shall be provided with a water supply system that maintains the following:

(a) An adequate supply of potable and of hot water:

(i) which conforms in quality to the Drinking Water Objectives of the Ontario Ministry of the Environment, February, 1978 edition; and the Guidelines for Canadian Drinking Water Quality, 1978;

(ii) which can provide at least 227.303 litres (50 gallons) per Resident and employee of the Operator, per day;

(iii) of at least .562 kilogrammes pressure per square centimeter (8 pounds per square inch), when a fixture is in use;

(iv) the temperature of the water serving all bath tubs, showers and hand basins used by Residents shall not exceed 49 degrees Centigrade (120 degrees Fahrenheit) and shall be controlled by a device, inaccessible to the Residents, that regulates the temperature".

(d) Ministry Guidelines s.3:

Similar to Hamilton by-law.

(e) Parkdale Working Group Report:

5. Hot Water. Each boarding home shall provide an adequate supply of hot water so that each occupant may take a bath or shower each day (the Sub-Committee had difficulty with this provision, and is of the opinion that 'adequacy' should be defined).

2. Toilet Facilities

(i) Number of Facilities:

(a) Housing By-law s.25:

(2) At least one water closet in good working order that is connected to the drainage system for the dwelling shall be accessible to and available for each 10 or fewer persons occupying every dwelling.

(3) At least one bath-tub or shower or combination bath-tub and shower that is

(a) in good working order,
(b) served with hot and cold running water, and
(c) connected to the drainage system for the dwelling

shall be accessible to and available for all persons occupying every dwelling unit.

(5) Subject to subsection (6), a wash-basin that is in good working order, served with hot and cold running water and connected to the drainage system for the dwelling shall be located in every room that contains a water closet or a urinal and such a wash-basin shall be accessible to and available for all persons in a dwelling.

(6) Notwithstanding subsection (5) where a dwelling contains not more than 3 dwelling units, the wash basin therein referred may be located in a room adjoining the room that contains a water closet or a urinal.

(b) Zoning By-law:

Boarding homes in R2, R3, R4, and R4A districts are required to have toilets, wash basins and baths or showers on the basis of one each for every six occupants.

(c) Hamilton By-law s.16:

(3) Toilet facilities shall be provided in at least the following ratios:

(a) for an authorized capacity of four to seven Residents: one wash basin, one flush toilet, and one bathtub or shower;

(b) for an authorized capacity of a fraction of seven Residents beyond the first seven: one wash basin and one flush toilet;

(c) for an authorized capacity of each additional seven Residents beyond the first seven: one wash basin, one flush toilet, and one bathtub or shower.

(d) Ministry Guidelines s.13(i):

(i) Toilet facilities shall be provided in the following ratio

(a) 1 w.c./1 w.h.l. per 8 occupants
(b) 1 tub or shower per 8 occupants

(e) Parkdale Working Group Report:

4. Bathtub or Shower. Each boarding house shall contain one bathtub for the occupants up to the first six persons permitted, thereafter a bathtub or shower shall be provided for each additional ten persons permitted. Each bathtub shall be fitted with a tight-fitting stopper to prevent leakage of water.

(ii) Privacy and Location of Toilet Facilities:

(a) Housing By-law s.25:

(4) A water closet or a urinal in a dwelling shall be located only within a separate bathroom or toilet room.

(7) Every bathroom and toilet-room in a dwelling shall

(a) be located within the main building that forms part of the dwelling,
(b) have provisions for privacy, and
(c) where the bathroom or toilet-room is used or is intended to be used by more than 1 roomer or boarder or by the occupants of more than 1 dwelling unit, have an entrance from a common passageway, hallway, corridor or other space used in common by the occupants of the dwelling.

(8) No person shall store or prepare food in a room that contains a water-closet or a urinal.

(c) Hamilton By-law s.161:

Similar to Housing By-law, also cannot "consume" food in room that contains a water closet.

(d) Ministry Guidelines s.13:

Same as Hamilton By-law.

(iii) Other Requirement:

(c) Hamilton By-law s.16,13,22(b):

16. (1) No toilet-room or bathroom shall be within, or open directly into, any dining room, kitchen, pantry, food preparation room or storage room.

(4) Bathrooms, toilets and shower rooms shall be provided with doors and shall not have locks unless they are of a type that can be readily released from the outside in an emergency.

(5) One bathroom, toilet and shower room shall be of a type that is suitable for use by persons confined to wheelchairs, where such persons are to be admitted as Residents.

(6) A small stepping stool shall be available for use with each toilet and bath tub.

(7) The bottom of each bathtub shall be furnished with non-skid material.

13. A rack on which to hang towels and face cloth shall be provided for each Resident.

22. (b) For each bathtub and each toilet, at least one grab bar or similar devide of a type tht will ensure the safety of Residents.

(d) Ministry Guidelines s.13:

Similar to Hamilton By-law.

3. Bedrooms

(i) Size

(a) Housing By-law s.31(3),(4),(5), and s.S.34(1):

Sleeping Use Prohibited

31. (3) Where a room in a dwelling,

(a) is less than 6 feet 6 inches in width, or (498-30),

(b) has a floor area of less than 65 square feet (498-80),

no person shall use or permit the use of the room for sleeping purposes.

Floor Area Computation:

(4) Where a room or part of a room in a dwelling does not exceed 4 feet 6 inches in height, the floor area under a ceiling that is not more than 4 feet 6 inches above the floor shall not be counted in computing the floor area of the room for the purpose of subsection (3). (498-80)

Low Ceiling Deemed Non-habitable:

(5) For the purposes of this section, a room that is less than 7 feet in height over more than one-half of the floor area shall be deemed to be a non-habitable room. (bedrooms are habitable rooms, s.2(5)

34. (1) Where a room in a dwelling is used for sleeping purposes by two or more persons simultaneously, the total number of persons using the room for sleeping purposes shall not exceed the floor area of.

(b) Zoning By-law:

No rooms shall be let in Boarding homes located in R2, R3, R4 or R4A districts unless the area of the bedroom is 9 square metres for a single occupant or 7 square metres for each one of two or more occupants.

Ontario Building Code:

Main bedroom area:

9.5.6.1(1) Except as provided in Article 9.5.6.3. at least one bedroom in every dwelling unit shall have,

(a) where built-in cabinets are not provided, a minimum floor area of 105 sq ft; or

(b) where built-in cabinets are provided, a minimum floor area of 95 sq ft.

(2) Except for buildings designed and constructed in accordance with CSA Standard Z-240.2.1-1979, the minimum dimension of the bedroom referred to in Sentence (1) shall be at least eight feet, ten inches.

Other bedroom areas:

9.56.2.(1) Except as provided in Article 9.5.6.3., each additional bedroom shall have,

(a) where built-in cabinets are not provided, a minimum floor area of 75 sq ft; or

(b) except for buildings designed and constructed in accordance with CSA Standard Z-240.2.1-1979, where built-in cabinets are provided, a minimum floor area of sixty-five feet.

(2) The minimum dimension within the area of a bedroom referred to in Sentence (1) shall be at least 6 ft 6 in.

Combination bedroom areas:

9.5.6.3. Bedroom spaces in combination with other spaces shall have at least 45 sq ft of floor area and have no dimension less than 6 ft 6 in. within the required area.

(c) Hamilton By-law s.7:

7. (a) A bedroom for a Resident or Residents in a House established before October 1, 1980, shall provide a minimum of 16.8 cubic metres (600 cubic feet) of air space and 6.96 square metres (75 square feet) of floor space for each Resident of the age of 16 years or over;

(b) A bedroom for a Resident or Residents in a House constructed, renovated, added to or altered on or after October 1, 1980, shall provide a minimum exclusive of the space provided for built-in or portable clothes closets, of

(i) 10.22 square metres (110 square feet) of floor space in a single-bed unit, provided that this area may be reduced to 9.30 square metres (100 square feet) where

the House provides a living room and a dining area(s),

(ii) 16.72 square metres (180 square feet) of floor space in a two-bed unit,

(iii) 25.08 square metres (270 square feet) of floor space in a three-bed unit, and

(iv) 29.73 square metres (320 square feet) of floor space in a four-bed unit,

for each Resident of the age of 16 years or over;

(d) Ministry Guidelines s.4(ii):

(ii) Each bedroom shall provide a minimum of 600 cu. ft. (16.99 cu. metres) of air space and 75 sq. ft. (6.968 sq. metres) of floor space per resident. In determining the area to be used for sleeping purposes, no account shall be taken of areas used for dining, sitting, recreation, food preparation, storage or laundry purposes, or that area of the residence defined in this guideline as a cellar.

(e) Parkdale Working Group Report:

5. A bedroom for Residents shall not be occupied for living or sleeping purposes by more than three Residents.

(ii) Bed Standards:

(c) Hamilton By-law s.8,10:

4. A bedroom for more than one Resident shall be furnished so that all beds are at least 91 metres (3 feet) apart.

10. Every bed for a Resident shall be a minimum width of 91.44 centimetres (36 inches).

(d) Ministry Guidelines s.4(iii):

Similar to Hamilton by-law.

(iii) Bedroom Clothes Closet:

(c) Hamilton By-law s.12:

12. A clothes closet for each Resident shall be provided in his bedroom.

(d) Ministry Guidelines s.5(iii):

Similar to Hamilton By-law.

(e) Parkdale Working Group Report:

Every bedroom shall contain storage facilities such as a cupboard or a wardrobe, so that each resident has a minimum of 24 cubic feet of storage space.

The storage facility shall be provided with a lock and operable only by the individual occupant.

4. Dining Room

(b) Ontario Building Code:

9.5.4.1.(1) A dining space in combination with other space shall have a minimum floor area of 85 sq ft.

(2) A dining room not combined with other space shall have a minimum area of 75 sq ft.

9.5.4.2. Except as permitted in Article 9.5.4.3., a dining room or space combined with other space shall have no dimension less than 7 ft. 6 in. within the required area measured between wall faces or a wall face and a built-in cabinet or appliance.

9.5.4.3. When a required dining area is provided in a kitchen or serves a bachelor dwelling unit, the minimum dimension of such space may be reduced to 5 ft. 6 in.

(c) Hamilton By-law s.14:

14. A dining area or areas shall be provided, with a minimum of 1.85 square metres (20 square feet) per Resident and accommodating at one time 50% of the authorized capacity of the House.

(d) Ministry Guidelines s.7:

Similar to Hamilton By-law.

(e) Parkdale Working Group Report:

2. Public Spaces. Each boarding house shall contain a dining room having an area not less than ten square feet times the number of the occupants permitted in

the boarding house, but in any case not less than 120 sq. ft.

Notwithstanding the requirements of No. 2 above, the dining area need not be provided within the boarding house if the owner or operator provides meals in some other facility under his direct control, and the provision of such meals is included as part of the rental paid by the occupant of the boarding house.

5. Common Area

(c) Hamilton By-law s.15:

SITTING ROOM(S)

15. (1) A sitting room or rooms shall be provided.

(2) The minimum total space for the sitting rooms shall be:

(i) calculated at the rate of 1.39 square metres (15 square feet) of floor space for each Resident, or

(ii) be 11.148 square metres (120 square feet),

whichever is greater.

(c) Ministry Guideline s.6:

Similar to Hamilton By-law.

(e) Parkdale Working Group Report:

3. Common or Recreational Area. Each boarding house shall have an area separate from and in addition to the dining area which is maintained exclusively for the use of the occupants permitted in the boarding house, having an area not less than five square feet times the number of persons occupying the boarding house, but in any case not less than 120 sq. ft.

6. Lighting

(a) Housing By-law s.28,29:

28. (4) Adequate lighting equipment shall be provided and maintained in good working order at all times in every

(a) stairway,
(b) hall,
(c) bathroom,
(d) shower-room,
(e) toilet-room,
(f) basement or cellar,
(g) laundry room,
(h) furnace room,
(i) similar non-habitable work-room, and
(j) kitchen

in a dwelling.

29. (8) Every storage room and every underground garage in a multiple occupancy building shall be illuminated by natural or artificial means on a level of illumination which averaged over 100 square feet of floor area and then at floor level shall not be less than 3 foot candles. (498-80)

(9) Every public and service area in a multiple occupancy dwelling other than a storage room or underground garage covered by sub-section (8) of this section shall be illuminated by natural or artificial means and the level of illumination measured at floor level equidistant from the light source shall not be less than the following: (498-80)

Room or Space	Candles
Service Rooms and Laundry Area	20
Public Water Closet Rooms	10
Public Corridors and Stairways	10
Service Hallways and Stairways	5
Recreation Rooms	10

(b) Ontario Building Code:

Illumination levels

3.2.8.1.(1) Every exit, public corridor, corridor providing access to exit for the public or serving patients' bedrooms or classrooms shall be equipped to provide illumination to an average level of at least 10 ft. candles at floor level and at all points such as

angles and intersections at changes of level where there are stairs or ramps.

(2) The average level of illumination in rooms and spaces used by the public shall be in accordance with Table 3.2.8.A.

(3) For the purpose of establishing the average level of illumination, at least one measurement of intensity of illumination shall be made for every 100 sq. ft. of floor area at the floor level.

TABLE 3.2.8.A.

Forming Part of Sentence 3.2.8.1(2)

Room or Space	Footcandles
Storage rooms	5
Service rooms and laundry areas	20
Storage garages	5
Public water closet rooms	10
Stairways	10
Service hallways	5
Recreation rooms	10
Column 1	2

Emergency lighting

3.2.8.2.(1) Emergency lighting shall be provided to average levels of at least 1 ft. candle at floor or tread level in,

(a) exists and corridors used by the public where such exits and corridors are below grade or are windowless;

(b) the following parts of buildings required by Subsection 3.2.4. to have a fire alarm system,

(i) exits,

(ii) corridors used by the public,

(iii) principal routes providing access to exit in an open floor area,

(iv) corridors serving patients' bedrooms, and

(v) corridors serving classrooms;

(c) underground walkways;

(d) covered malls; and

(e) floor areas or parts thereof where the public may congregate in,

(i) Group A, Division 1 occupancies, and

(ii) Group A, Division 2 and 3 occupancies having an occupant load of 60 persons or more.

Emergency power

(2) An emergency power supply shall be provided to maintain the emergency lighting required by this Subsection from a power source such as batteries or generators that will continue to supply power in the event that the regular power supply to the building is interrupted and be so designed and installed that upon failure of the regular power it will assume the electrical load automatically for a period of,

(a) 2-hr for all buildings within the scope of Subsection 3.2.6.;

(b) 1-hr for buildings of Group B major occupancy classification that are not within the scope of Subsection 3.2.6.; and

(c) 1/2-hr for buildings of all other occupancies.

(3) Where an emergency power generator is supplied from an energy source outside of the building, provision shall be made to ensure its operation in the event of an emergency.

(c) Hamilton By-law s.19:

19. The following minimum levels of illumination shall be provided:

(1) 161.45 lux (15 foot-candles) continuous lighting in all corridors, halls, at floor level;

(2) 215.28 lux (20 foot-candles) continuous lighting in all stairways, landings;

(3) (a) 107.64 lux (10 foot-candles) in all bedrooms
(b) 376.74 lux (35 foot-candles) at bed reading position;

(4) 1076.4 lux (100 foot-candles) for drug cabinets;

(5) (a) 322.92 lux (30 foot-candles) in general kitchen
(b) 538.2 lux (50 foot-candles) on range tops and kitchen work surfaces
(c) 753.48 lux (70 foot-candles) on kitchen sink;

(6) 322.92 lux (30 foot-candles) in washrooms;

(7) 322.92 lux (30 foot-candles) in game rooms;

(8) 107.64 lux (10 foot-candles) plus local lighting in living room;

(9) 322.92 lux (30 foot-candles) in laundry;

(10) Lighting in other areas of the House shall comply with Illuminating Engineering Society Standards.

(11) 10.76 lux (1 foot-candle) as emergency lighting for all means of egress in Houses which are required to have a fire alarm system."

(d) Ministry Guidelines s.9:

A minimum level of lighting shall be maintained throughout the home which will enable the residents to carry out their various activities comfortably, safely and without visual fatigue.

Explanatory Notes

The following are recommended minimum lighting intensities related to general lighting:

i) Public Halls, corridors, stairways, landings, (measured at floor level or tread) - 10 ft. candle (107.64 lux)

ii) Bathroom, toilet room (measured at 30" (76.2 cm.) above floor level) - 30 ft. candle (322.92 lux)

iii) Kitchens (measured at 30" (76.2 cm.) above floor level) - 50 ft. candle (538.2 lux)

7. Temperature

(a) Housing By-law s.23a:

23a. Every dwelling shall between the 15th day of September in each year and the 1st day of June of the following year be provided with heat so that a minimum temperature of 70 degrees Fahrenheit (21 degrees Celsius) is maintained in each dwelling unit, except that where the occupant of the dwelling can regulate the temperature within his own dwelling unit, the minimum temperature does not apply. (500-80)

(c) Hamilton By-law s.20:

From September 15 until May 31, and at all other times when heating may be reasonably necessary for the preservation of health, the temperature of all rooms and halls shall be maintained at not less than 20 degrees Centigrade (70 degrees Fahrenheit).

(d) Ministry Guidelines s.10:

A minimum of 21 degrees C (70 degress F) shall be maintained at all times.

Explanatory Notes

For the purposes of this section, temperature readings shall be measured at a distance of 3' (91.44 cm.) or more from the exterior walls and at a height of 2' (60.96 cm.) above the floor level.

8. Ventilation

(a) Housing By-law s.28:

(5) (a) Every habitable room, bathroom, shower room, toilet room, garbage or refuse room, laundry room, locker and storage room and all parts of a dwelling shall be provided with adequate

natural or artificial means of ventilation; (498-80)

(b) The minimum ventilation to be provided for rooms in a dwelling shall be as follows: (498-80)

Minimum Ventilation Requirements

	Location	Minimum Unobstructed Area
Within Dwelling Units	Bathrooms or water-closet rooms	1 sq. ft.
	Unfinished basement space	0.2 % of the floor area
	Dining rooms, living rooms, bedrooms, kitchens, combined rooms, dens, recreation rooms and all other finished rooms	3 sq. ft.
	Bathrooms or water-closet rooms	1 sq. ft. per water-closet
Other than within Dwelling Units	Laundry rooms, kitchens, recreation rooms	4 % of the floor area
	Corridors, storage rooms and similar public rooms or spaces	0.2 % of the floor area

(6) Where any system of mechanical ventilation is provided in any room in a dwelling, it shall be

(a) capable of completely changing the air in the room at least once per hour, and

(b) maintained in good repair and working order at all times.

(c) room air conditioners should be equipped so as to prevent condensation drainage on entrance areas, sidewalks and walkways. (498-80)

(7) All enclosed spaces within a dwelling shall be adequately ventilated, and access of sufficient size

to permit entry shall be provided thereto and fitted with a door or panel to enclose the opening.

(b) Ontario Building Code:

Section 6.2 provides extensive regulations regarding ventilation systems.

(c) Hamilton By-law s.9, s.21:

s.21 Every room shall be adequately ventilated by natural or mechanical means and shall be so designed and installed that it meets the requirements of sections 6.2 and 9.33 of the Ontario Building Code. Such ventilation shall be installed only after plans have been approved and a building permit issued, by the Chief Building Official.

s.9 A bedroom for one or more Residents shall

(a) have one or more windows to the outside that,

(i) except where another means of ventilation is provided, can be opened to provide an open area equal to 5% of the floor area of the room,

(ii) is not less in total area than 10% of the floor area of the room,

(iii) is screened from May 1 to October 31,

(b) not be part of a lobby, hallway, passageway, closet, bathroom, stairway, basement, attic, kitchen, storage room, boiler room, laundry room, activity room, utility room, chapel, sitting room, administrative office, or resident examination room.

(d) Ministry Guidelines s.8:

Similar to Hamilton By-law s.9, with the following addition:

Where mechanical ventilation is provided, the following rates will generally be adequate for removing excess heat, humidity and odours:

i) Kitchen ... ... 15 air changes p.hr.

ii) Bathroom and toilet rooom ... ... 8 -do-

iii) Family, recreation and laundry rooms... 6 -do-

9. General Safety

(a) Housing By-law s.19(3):

19. (1) Every Stairway, balcony or porch in, on or appurtenant to a dwelling shall be maintained

(a) in good repair
(b) free from
(i) holes
(ii) cracks
(iii) excessive wear and warping, and
(iv) other defects that are accident hazards.

(2) Without restricting the generality of sub-section (1) the maintenance includes

(a) repairing or replacing treads, risers or floors that show excessive wear or are broken, warped or loose,
(b) repairing, renewing or supporting structural members that are rotted, deteriorated or loose
(c) painting,

(3) Every open side of a stairway, flat roof to which access may be gained through a doorway, terrace, balcony, porch, landing or stair-well shall have a rigid guardrail not less than 3 feet high with an intermediate rail, or balustrade not less than 3 feet high, in good repair firmly attached so as to provide reasonable protection against accident or injury.

(a) where the vertical rise between the base of the stairway and the top of the stairway exceeds 4 feet, or
(b) where the flat roof, terrace, veranda, porch landing or stairwell

(i) is more than 2 feet above the ground, floor or other horizontal plane below, and
(ii) can be used by any person who is in, on or at the dwelling.

(4) Every stairway that does not require a guardrail or balustrade under subsection (3) shall have a rigid handrail not less than 32 inches high and not more than 36 inches high in

good repair on at least one side of the stairway firmly attached so as to provide reasonable support for persons using the stairway. (498-80)

(b) Ontario Building Code:

9.8.7.1. Except as permitted in Articles 9.8.7.2. and 9.8.7.3., a handrail shall be provided on at least 1 side of stairs less than 44-in. in width, and on 2 sides of stairs 44-in. in width or greater.

9.8.7.2. Handrails are not required for stairs within a dwelling unit that have fewer than 3 risers.

9.8.7.3. Only 1 handrail is required on exterior stairs more than 44-in. in width and having 3 or more risers provided such stairs serve not more than 1 dwelling unit.

9.8.7.4. Handrails on stairways shall be located between 32 and 36-in. measured vertically above a line drawn through the outside edges of the stair nosings.

9.8.7.5. A clearance of at least 1 1/2-in. shall be provided between each handrail and the wall to which it is fastened.

9.8.7.6. Handrails shall be so constructed that there will be no obstruction on or above them to break a handhold.

9.8.7.7. Handrails and stair stringers shall not project more than 3 1/2-in. into the required width of stairway.

9.8.7.8. Where ramps are used in lieu of stairs, the handrail requirements for stairs in Article 9.8.7.1., and Articles 9.8.7.3. to 9.8.7.7. shall apply where the gradient exceeds 1 in 10.

(c) Hamilton By-law s.22:

22(2) The following shall be provided:

(a) handrails, of a type that will ensure the safety of Residents, installed on each side of every stairway that is wider than 111.76 cm (44"); on at least one side of each stairway that is 111.76 cm (44"), or less, in width; and on the open side of each stairway or landing, with the top of

each handrail not less than 76.2 cm (30") nor more than 106.68 cm (42") above the finished floor or stair level;

(c) non-skid finishes and coverings on floors and stairways; and

(d) balustrades on the open sides of every stairway, landing, balcony, raised porch, or roof to which Residents have access; no opening in any such balustrade shall be more than 10.16 cm (4") wide.

(d) Ministry Guidelines s.11:

Similar to Housing By-law and Hamilton By-law.

10. Fire Safety

(a) Housing By-law s.18a,29a,29b:

The by-law provides specific standards relating to fire escapes and fire alarm systems

(b) The Fire Code, Reg. 730-81 under the Fire Marshals Act, provides extensive regulations to promote fire safety.

(c) Hamiton By-law s.23,24:

the by-law provides extensive regulations which exceed the requirements of The Fire Code.

(d) Ministry Guidelines s.12:

i) All rest homes shall be required to maintain fire safety standards as specified in reg. 24 and 25, Regulation 437 Homes for Special Care.

ii) Each home shall be provided with an approved fire extinguisher on each floor.

iii) Every operator shall ensure that the home is inspected on an annual basis by the local fire authority.

11. Refuse Disposal:

(a) Housing By-law s.9:

9. All garbage, rubbish and other debris from a dwelling shall be promptly stored in regulation receptacles and made available for removal in accordance with the provisions of By-law No. 20298 of the Corporation, as amended.

Note: By-law No. 20298 defines a regulation receptacle as a "properly covered water-tight, metal container of circular design, having a capacity of not more than two cubic feet.

(c) Hamilton By-law s.18:

18. (1) Rubbish and garbage shall be stored in receptacles which are:

(a) insect and rodent proof;
(b) water tight;
(c) provided with a tight-fitting cover;
(d) kept clean.

(2) Ashes shall be stored in a metal container which has a tight-fitting cover.

(d) Ministry Guidelines s.14:

Similar to Hamilton By-law.

12. Cleanliness

(a) Housing By-law s.29:

29. (3) Every

(a) passageway
(b) hallway
(c) corridor
(d) entrance
(e) lobby
(f) means of egress
(g) living room
(h) dining room
(i) recreation room
(j) kitchen
(k) bathroom
(l) shower room
(m) toilet room
(n) other area (413-74)

used in common by the occupants of a multiple occupancy dwelling shall be maintained in a clean and sanitary condition.

(4) Without limiting the generality of sub-section (3), the maintenance includes:

(a) regular cleaning of the floors and walls;
(b) covering the floors with a durable material that is free from cracks, holes or other defects that retain dirt or are health or accident hazards;
(c) covering the walls with a durable material that is resistant to cracking, scratching or breaking or alternatively regularly painting or decorating so as to provide a finished surface which can be easily cleaned, and painting or decorating the ceilings. (413-74)

(c) Hamilton By-law s.17:

17. The House shall be kept clean and sanitary.

(d) Ministry Guidelines s.2:

All premises should be maintained in a sanitary and safe condition to the satisfaction of the Medical Officer of Health.

(e) Parkdale Working Group Report:

Cleanliness. The floors of all kitchens, dining rooms, bathrooms, common rooms and common passageways shall be swept and washed daily. The floor of all bedrooms and other habitable areas shall be swept daily and washed at least once per week.

13. Window Maintenance

(e) Parkdale Working Group Report:

6. Windows and Drapes - All windows in a boarding house shall be provided with drapes or blinds and all windows shall be cleaned inside and out every six months, and the window coverings including drapes and blinds shall be kept in a clean condition and washed periodically to maintain them in that condition.

14. Letter Box

(e) Parkdale Working Group Report:

5. Letter Box. Each boarding house to contain a letter box for each occupant permitted, in the front of premises on which the name of the individual occupant is posted.

II PERSONAL CARE STANDARDS

1. Nutritional Care

(c) Hamilton By-law s.34:

The operator shall ensure that the Residents are served daily with sufficient food of good quality and adequate nutritional and caloric value.

(d) Ministry Guidelines s.15:

Similar to the Hamilton By-law.

(e) Parkdale Working Group Report:

3. Menu. The owner or operator shall post in the dining area on a weekly basis, a menu detailing the food to be served at each individual meal during that particular week. Where meals are provided in some other place, other than the boarding home, a menu shall be posted in the boarding house in a conspicuous place.

4. Nutrition. A standard for balanced quantity and quality of food, be authorized by a dietitian appointed by the regulating body.

2. Linen and Towels

(c) Hamilton By-law s.11:

11. (1) Sufficient clean towels, face cloths and bed linen shall be provided for use of the Residents, and a supply of such linen shall be on hand at all times in the House.

(2) In any event, towels, face cloths and bed linen shall be changed at least once a week.

(d) Ministry Guidelines s.5, s.13:

Similar to the Hamilton By-law.

(e) Parkdale working Group Report:

1. Beds and Bedding. The owner or operator shall provide a bed for each occupant permitted in a sleeping room. Such bed shall be provided with a mattress and pillow and shall have two sheets and two blankets, and a pillow slip. The sheets and pillow slip shall be washed once per week and the blankets washed once per month. All bedding shall be changed by the owner or operator when the occupancy of the bed changes.

2. Provisions of Bathing. The owner or operator shall provide each occupant with a bath towel once per week. The owner or operator shall also provide each occupant with sufficient toilet tissue and hand soap for their individual needs.

3. Control of Drugs

(c) Hamilton By-law s.33:

33. The operator shall ensure that all prescription drugs:

(1) are kept in one or more locked drug cabinets,

(2) are made available only to those Residents for whom they have been prescribed, as directed by the physician.

(d) Ministry Guidelines s.16:

Similar to the Hamilton By-law.

(e) Parkdale Working Group Report:

7. Medicine Cabinet. Each operator or owner shall provide a medicine cabinet of sufficient dimensions to store medication given to him for safekeeping by the occupants of the boarding house. The cabinet shall be locked and the key kept in the possession of the owner or operator. The cabinet shall also contain a detailed list of the contents which is

kept up to date on a daily basis by the owner or operator, and is available for inspection by an inspection agency upon request.

Other Personal Care Standards

The standards provided by the Hamilton By-law and the Ministry Guidelines are similar with regard to the following matters:

- Admission of Residents
- Medical Care
- Nursing Care
- Kitchen
- Operators and Employees Qualifications
- Guidance and Supervision by Staff
- Records and Reports
- Inspection of the Boarding Home

APPENDIX B

GREATER VANCOUVER MENTAL HEALTH SERVICE:

VENTURE

In-Patient and After-Hours Psychiatric Emergency Service (A.H.P.E.S.)

Expenditures 1982/1983

Venture Salaries including A.H.P.E.S. and on-call (not including on-call psychiatrists)*	$435,046
Employee Benefits: (9.4% of Total Salary Expendiutres)	45,983
Total Salaries and Benefits	$480,129
Fixed Asset Expenditures: (frozen in 1982/83 except for emergencies)	2.981
General Operating Expenses	36,460
Total G.V.M.H.S. Expenditures	519,570

Provincial Funds paid direct:

Cook	$20,000
Rent	25,000

* Psychiatrists from the community care teams are available to the A.H.P.E.S. on a weekly rotation basis through an on-call and call-out system. G.V.M.H.S. reports that this system is very expensive and must be negotiated in advance.

From: Financial Statement
March 31, 1983

APPENDIX C

PROPOSED CRISIS CENTRE (15 RESIDENTS)

FUNDING ESTIMATES

STAFFING			
1	Coordinator	$ 31,500	
9	Nurses	228,600	
3	Health Care Workers	60,000	
1	Secretary	17,500	
1.5	Cooks	29,000	
	Vacation Relief	22,000	
	Shift Premium	7,000	
	On Call Staff	4,500	
	On Call Psychiatrists	64,000	
	Sessional (3)	27,900	$492,000
	Employee Benefits 15%		73,800
OTHER EXPENSES			
	Lease - Automobile	$ 3,000	
	Office Supplies	5,000	
	Telephone	3,500	
	Travel	3,000	
	Maintenance and Janitorial	3,500	
	Staff Education	3,500	
	Bookkeeping Services	7,500	
	Audit Services	2,500	
	Insurance	4,000	
	Legal	1,500	
	Advertising	2,500	
	Food Cost	16,500	
	Kitchen Supplies	3,000	
	Kitchen Equipment	5,000	
	Furniture	15,000	79,000
	TOTAL		$644,800

NOTES TO PROPOSED FINANCIAL ESTIMATES

1) Provision for rent, property taxes and utilities were excluded.

2) Kitchen equipment and furniture purchases are one time expenditures.

3) Renovation cost has not been taken into consideration.

4) Provision for psychiatrists on call and sessional will require future review.

Prepared with the assistance of Ontario Ministry of Health.

POOR

QUALITY

ORIGINAL